

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150017	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
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NAME OF PROVIDER OR SUPPLIER LUTHERAN HOSPITAL OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 7950 W JEFFERSON BLVD FORT WAYNE, IN 46804
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S000000	The visit was for a licensure survey. Facility Number: 005016 Survey Date: 8-19-13 to 8-21-13 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Steve Poore, BS MLT Medical Surveyor 3 QA: clauglin 08/30/13	S000000		
S000102	410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a) (a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on contract staff personnel file review, document review, and interview, the facility failed to ensure that state rules and regulations were complied with in reference to IC 16-28-13 for one PCT. (patient care tech-N9)	S000102	A certification verification was completed on 8/22/2013 PCT N9 and added to the staffing file. A criminal background check was also completed on 8/22/2013 for PCT N9 and added to the staffing file. The Director of Human Resources has scheduled a	08/22/2013

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>Findings:</p> <p>1. at 10:15 AM on 8/21/13, a review of IC 16-28-13-4, with staff member #70, the RN (registered nurse) acute care manager of contracted dialysis services, indicated that:</p> <p>a. "Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or (2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility; shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 10-13-3 or another source by law."</p> <p>2. at 9:15 AM on 8/21/13, review of the contracted dialysis PCT employee file indicated:</p> <p>a. PCT N9 began working at this facility on 7/1/13</p> <p>b. there was no documentation of state registry/home health aide check being performed at the time of hire</p> <p>3. interview with staff member #70, the RN acute care manager of contracted</p>		meeting in October with the contracted service to develop a new process and policy for managing new hire verifications for licensure, criminal background checks, and immunizations.				

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S000178	<p>dialysis services, indicated that:</p> <p>a. it was unknown that the home health aide registry needed to be checked with newly hired unlicensed patient care givers</p> <p>4. interview with staff member #67, the human resources manager, at 10:40 AM on 8/21/13, indicated:</p> <p>a. home health aide registry checks are performed by this facility with newly hired unlicensed patient care techs</p> <p>b. employee data of contracted agencies is not shared with human resources to verify that all new hire requirements are met to the facility's satisfaction</p> <p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and interview, the facility failed to post a copy of its current license in a common public area</p>	S000178	Current license posted on 9/11/2013 in all four locations listed on the report: Outpatient Imaging patient waiting area;	09/12/2013			

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	<p>open to patients and public for 3 service locations operated under the hospital license.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a tour on 8-20-13 at 1050 hours, no State license was observed in the outpatient imaging patient waiting area. 2. During a tour on 8-20-13 at 1055 hours, no State license was observed in the women ' s center public waiting area. 3. During an interview on 8-20-13 at 1055 hours, staff A9 and A15 confirmed the off-site locations lacked a posted license. 4. During a tour on 8-20-13 at 1135 hours, an expired State license was observed in the outpatient rehabilitation patient waiting area. 5. During an interview on 8-20-13 at 1135 hours, staff A9 and A17 confirmed the off-site location lacked a valid posted license. 		<p>Women's Center public waiting area; Off-site locations; and Outpatient Rehabilitation patient waiting area. All four areas were visually inspected for validation of posting on 9/12/2013. The Director of EOC has added licensure posting verification to the Environment of Care (EOC) rounding form for continued validation that a current license is posted in all public patient area's.</p>		

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S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</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: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and interview, the facility failed to maintain and review its policies/procedures at least every two years.</p> <p>Findings:</p> <p>1. The administrative memorandum [policy] titled Organization of Manuals (approved 5-12) indicated the following: " Policies affecting more than three divisions are to be established as administrative memorandums ...the COO (chief operating officer) will conduct a review of the administrative memorandums every two years. "</p> <p>2. The administrative memorandum [policy] titled Policy Review (approved 5-12) indicated the following: " All administrative memorandums will be</p>	S000322	<p>Policy number GN01.16, titled "Policy Review" will be updated to state "All Administrative Memorandums will be updated as needed and reviewed every two years." The remainder of the policies listed under S-0608 are nursing policies instead of administrative memorandums as stated within the report but still require review every two years. The identified administrative memorandums and nursing policies will be reviewed and updated by 10/4/13 (delay past 30 days due to COO no present for final review & signature). The Director of Quality Services will review all policies to ensure they are updated accordingly.</p>	10/04/2013			

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	<p>updated as needed and reviewed at least triennially. "</p> <p>3. During an interview on 8-21-13 at 1420 hours, staff A3 confirmed that the two administrative memorandums failed to indicate a consistent timeframe for review and had not been maintained.</p> <p>4. Review of the administrative memorandums [policies] titled Electrical Safety (approved 7-06) and Health Services for Associates (approved 2-11) failed to indicate that a review had been performed within the past 2 years. The policy/procedures Toy Cleaning (approved 3-10), OR Room Cleaning (approved 7-10), Procedure for OR Room Cleaning (approved 7-10), OR Dress Code (approved 7-10) and Medication Incidents (approved 8-10) failed to indicate that a review had been performed within the past 2 years.</p> <p>5. During an interview on 8-21-13 at 1420 hours, staff A3 confirmed that the administrative memorandums and policy/procedures had not been reviewed within the past 2 years.</p>				

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S000394	<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.</p> <p>Based on document review, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 19 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 8-20-13 at 0900 hours, a list of contracted services was received from staff A2. The list failed to indicate a provider for air exchange certification, biohazardous waste, elevators, exhaust hoods, 4 fire services, generators, medical vacuum, medical transcription, patient beds, pest control, 6 radiology services and sterilizers. Review of facility documentation indicated the following: air exchange certification by CS1, biohazardous waste service by CS2, elevator service by CS3, exhaust hoods by CS4, fire panel 	S000394	The Vice President of Quality Services and the Director of Quality Services are currently reviewing options for tracking quality assurance for contracted services. Discussion has taken place at Quality Council (8/26/2013) regarding the requirement to track and report this information to the Medical Executive Committee and the Governing Board. A system will be identified by the end of October 2013 and fully implemented by the end of 4th Quarter 2013.	10/31/2013			

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S000406	<p>certification by CS5, fire sprinkler and backflow prevention service by CS6, fire extinguisher service by CS7, generator service by CS8, medical vacuum service by CS9, patient bed service by CS10, pest control service by CS11, radiology equipment manufacturer services by CS12, CS13, CS14, CS15 and CS16, radiation exposure monitoring by CS17, sterilizer service by CS18 and medical transcription by CS19.</p> <p>3. On 8-21-13 at 1415 hours, staff A3 confirmed the list of contracted services failed to include the providers identified through facility documentation.</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. Based on document review and interview, the facility failed to ensure</p>	S000406	The facility documentation for utilities management review is completed monthly by the	10/31/2013

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	<p>that all services were evaluated and reviewed through the Quality Assessment/ Performance Improvement Program (QAPI) program for 7 direct services and 18 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The Performance Improvement Plan 2013 (no approval date) lacked a provision for monitoring, evaluating, and reporting all services including contracted services provided at the facility. 2. The 2013 Quality Council minutes lacked documentation of monitoring and reporting for the direct services of cardiac rehabilitation, endoscopy, inpatient rehabilitation, PICC line (peripherally-inserted central catheter), respiratory therapy, sleep lab and speech pathology. 3. During an interview on 8-21-13 at 1400 hours, staff A3 confirmed that the 2013 minutes lacked evidence of monitoring and review for the 7 services. 4. Facility documentation indicated that the following services were provided under contract or informal agreement at the facility: air exchange certification by 		<p>Director of Environment of Care (EOC), along with the Construction/Compliance Coordinator, during the Environment of Care Committee meetings which includes review (according to the reporting schedule) for the areas listed in the survey report: air exchange certification by CS1, biohazardous waste disposal by CS2, elevator service by CS3, exhaust hoods by CS4, fire panel certification by CS5, fire sprinkler and backflow prevention service by CS6, fire extinguishers by CS7, generator service by CS8, medical vacuum by CS9, patient beds by CS10, pest control by CS11, radiology equipment manufacturer services by CS12, CS13, CS14, CS15 and CS16, radiation exposure monitoring by CS17 and sterilizer service by CS18. The Vice President of Quality Services and the Director of Quality Services are currently reviewing options for tracking quality assurance for contracted services. Discussion has taken place at Quality Council (8/26/2013) regarding the requirement to track and report this information to the Medical Executive Committee and the Governing Board. A system will be identified by the end of October 2013 and fully implemented by the end of 4th Quarter 2013. The Performance Improvement Plan for 2013 was updated on 8/26/2013 to include</p>		

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	<p>CS1, biohazardous waste disposal by CS2, elevator service by CS3, exhaust hoods by CS4, fire panel certification by CS5, fire sprinkler and backflow prevention service by CS6, fire extinguishers by CS7, generator service by CS8, medical vacuum by CS9, patient beds by CS10, pest control by CS11, radiology equipment manufacturer services by CS12, CS13, CS14, CS15 and CS16, radiation exposure monitoring by CS17 and sterilizer service by CS18.</p> <p>5. The 2012 and 2013 Quality Council minutes lacked documentation of monitoring and reporting for the 18 contracted services.</p> <p>6. During an interview on 8-21-13 at 1415 hours, staff A3 confirmed that the 18 services were not being evaluated and reviewed through the QAPI program.</p>		<p>the following responsibility for Quality Council: Review all services furnished directly by hospital staff and those services provided under contract, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities.</p>		

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S000422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be</p>			
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	<p>identified by a hospital that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p>			

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	<p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2) Based on document review and interview, the hospital failed to maintain and follow its policy/procedure and ensure that a reportable event was submitted to the Indiana State Department of Health (ISDH).</p> <p>Findings:</p> <p>1. The administrative memorandum [policy] titled Indiana State Department of Health - Serious Adverse Reporting (approved 5-12) failed to indicate a provision for submitting to the ISDH no later than 4 months after any potential reportable event brought to the attention of the quality assessment and performance improvement (QAPI) program. The [policy] indicated the following: " Any serious adverse event that involves issues related to clinical skill/judgment shall be referred to the Medical Staff Peer Review Committee ...[and] ...The Chief Quality Officer shall submit a report to the ISDH as soon as reasonably and practicably possible, but no later than fifteen (15) working days after the serious adverse event is determined to have occurred ... "</p> <p>2. Quality Council meeting minutes</p>	S000422	The Vice President of Quality Services reported the Serious Adverse Event to the Indiana State Board of Health (ISDH) on 8/22/2013 after extensive review and investigation took place to determine if the event qualified as a reportable event. The case was reviewed by Peer Review which requested further review by the Cardiovascular/Cardiology Clinical Service group for final determination which occurred on 5/22/2013 with final reporting to Quality Council on 6/24/2013. Reporting on 8/22/2013 to ISDH falls within the 4 month timeframe allowed by ISDH for Reportable Events.	08/22/2013			

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	<p>dated 6-24-13 indicated that a surgical error as defined by 410 IAC 15-1.4-2.2(a)(1)(A)(i) Reportable Events and by the facility [policy] titled ISDH - Serious Adverse Reporting was presented and discussed at the committee meeting. On 8-21-13 at 1015 hours, staff A3 was requested to provide additional documentation regarding the event and subsequent investigation and none was provided prior to exit.</p> <p>3. During an interview on 8-21-13 at 1120 hours, staff A3 indicated that the reportable event had been submitted to the Medical Staff Peer Review Committee for review.</p> <p>4. During an interview on 8-21-13 at 1230 hours, the Chief Quality Officer A2 confirmed that the reportable event had not been submitted to the ISDH.</p>			

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S000522	<p>410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1(c)(1)(2)(A)(B)(C)</p> <p>(c) The dietary service shall do the following:</p> <p>(1) Provide for liaison with the hospital medical staff for recommendation on dietetic policies affecting patient treatment.</p> <p>(2) Correlate and integrate dietary care functions with those of other patient care personnel which include, but are not limited to, the following:</p> <p>(A) Patient nutritional assessment and intervention. (B) Recording pertinent information on the patient's chart. (C) Conferring with and sharing specialized knowledge with other members of the patient care team.</p> <p>Based on policy and procedure review, observation, and interview, the nutritional services department failed to implement their policy related to refrigerator cleaning for 6 refrigerators observed while touring.</p> <p>Findings: 1. at 4:50 PM on 8/19/13, review of the "Nutritional Services Policy", "Floor Stock for Patients", with a file number of 23.10.2 and dated 2/12, indicated: a. on page two, it reads: "Cleaning responsibilities will be divided among Nutritional Services, Environmental</p>	S000522	The Director of Nutritional Services updated policy number 23.10.2 to include the areas sited during the survey as being deficient in cleaning patient refrigerators (Emergency Department; CVIC; Childbirth Center; and Pediatrics). The patient refrigerators for all four areas have been added to the weekly cleaning schedule and will be cleaned by Nutritional Services. Nutrition Service staff informed of updated responsibilities and expectations. Visual inspection validated cleaning had occurred in all four areas on 9/20/2013. Ongoing	09/20/2013			

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	<p>Services, and Nursing Services....Nutritional Services...Responsibilities...Refrigerator s..."</p> <p>b. an attachment with a "Stocking Schedule", and a "Cleaning Schedule" indicated which days of the week each nursing unit refrigerator would be cleaned by nutritional services staff (the emergency department was not on the schedule)</p> <p>2. while on tour of the ED (emergency department) on 8/19/13 at 12:35 PM on 8/19/13, in the company of staff members #53, the vice president of nursing and chief nursing officer, and #55, the ED nurse manager, it was observed that the pantry (patient food) refrigerator had: dirty refrigerator shelves; a large amount of dried brown liquid under the vegetable drawers; and dried liquids/crumbs/debris in the vegetable drawers</p> <p>3. interview with staff member #55, the ED nurse manager, at 12:40 PM on 8/19/13 indicated the refrigerator is not on any cleaning schedule</p> <p>4. while on tour of the CVIC (cardio vascular intensive care) unit at 10:55 AM on 8/20/13, in the company of staff member #60, the CVIC nurse manager,</p>		inspection to take place during Environment of Care rounds per schedule.	

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	<p>it was observed that the pantry (patient) refrigerator was dirty under the vegetable drawers</p> <p>5. interview with staff member #60, the CVIC nurse manager, at 12:45 PM on 8/20/13 indicated nutritional services is responsible for keeping the pantry refrigerators clean</p> <p>6. while on tour of the CBC (childbirth center) on 8/19/13 at 2:45 PM and 2:55 PM, in the company of staff member #61, the CBC nurse manager, it was observed that two patient food refrigerators were found to be dirty with large amounts of crumbs/debris under the vegetable drawers</p> <p>7. interview with staff member #61, the CBC nurse manager, at 3:00 PM on 8/19/13, indicated the responsibility for cleaning refrigerators is with nutritional services</p> <p>8. while on tour of the pediatric nursing unit at 3:50 PM and 4:00 PM on 8/19/13, in the company of staff member #62, the pediatric nurse manager, it was observed that:</p> <p>a. two pantry (patient) refrigerators were dirty on the freezer shelves, under the vegetable drawers, and one with a dried milk-like substance on an upper</p>			

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	<p>refrigerator shelf</p> <p>b. a microwave in the pantry area was splattered with dried food/liquid on the walls and door</p> <p>9. interview with staff member #62, the pediatric nurse manager, at 4:00 PM indicated the two pediatric refrigerators and microwave were not clean</p> <p>10. interview with staff member #66, the director of nutritional services, at 9:40 AM on 8/20/13 indicated:</p> <p>a. this staff member just started at the facility a few months ago and was told by staff that refrigerators were being cleaned by environmental services staff</p> <p>b. it was unknown that the current policy still indicates nutritional services will clean nursing unit refrigerators</p> <p>c. microwave ovens are not currently on any cleaning schedule</p> <p>d. the ED is not listed on the weekly cleaning schedule as an area to clean</p>			

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S000592	<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 and interview, the infection control (IC) committee failed to ensure that the operating room (OR) cleaning and disinfecting was performed in a safe and effective manner for the surgery department of the facility.</p> <p>Findings:</p> <p>1. The environmental services policy/procedure Cleaning OR (reviewed 1-12) failed to indicate it had been reviewed by the Infection Control Committee.</p> <p>2. The surgical services policy/procedure titled Procedure for OR Room Cleaning (approved 7-2010)</p>	S000592	The Director of Environment of Care, Infection Control Practioner, along with the Director of Environmental Services (EVS) are reviewing policies 4.02.21 (OR Room Cleaning) and 4.02.22 (Procedure for OR Room Cleaning) to compare against current evidence based practice for updates or changes that need to be done. Findings from ISDH survey were discussed at Infection Control Committee on 9/25/2013. Recommendations received to review current practice at The Orthopedic Hospital and see if that can be implemented here. Once the new process is approved, all EVS staff will be trained and competencies will be validated. A checklist has been developed and will become part of the	09/25/2013			

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S000596	<p>failed to indicate it had been reviewed by the Infection Control Committee and failed to indicate that it was applicable for environmental services personnel.</p> <p>3. During an interview on 8-20-13 at 1345 hours, the IC nurse A16 confirmed that the policy/procedures failed to indicate evidence of recent review and approval by the IC committee.</p> <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 policy and procedure review, observation, and interview, the infection control committee failed to ensure that consistency for toy cleaning was obtained between three separate policies reviewed, and failed to ensure the proper disinfection of toys in two areas</p>	S000596	<p>EVS staff competencies.</p> <p>The Infection Control Practitioner has discussed the need for consistency in cleaning toys with the Director of Rehabilitation Services and the Pediatrics Nurse Manager. Policy revisions were reviewed and approved by Infection Control Committee on</p>	09/25/2013

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	<p>observed.</p> <p>Findings:</p> <p>1. at 4:15 PM on 8/19/13, review of the policy and procedure "Playroom Safety", policy number 6.27.08, with a last reviewed date of May 2011, indicated:</p> <p>a. under section "IV. Action Directive", it reads: "...C. Pediatric personnel will cleanse all toys when they are removed from patient's room, before returning them to the playroom. 1] cleanse with soap and water. 2] Cleanse with approved germicide. 3] Rinse and dry. D. toys in playroom will be cleaned after each use with germicide spray and checked for safety before replacing in cabinets."</p> <p>2. review of the policy and procedure "Toy Cleaning" (Infection Control), "file" number 03.49P, with a most recent date of 03/10, indicated:</p> <p>a. under "Policy", it reads: "All shared toys within the hospital are cleaned and disinfected regularly and when visibly soiled or mouthed."</p> <p>b. under "Frequency of Cleaning", it reads: "...2. Wall-mounted or table-mounted toys should be cleaned and disinfected weekly and when visibly soiled. 3. Toy storage boxes, drawers or shelves should be cleaned and disinfected weekly and when visibly</p>		<p>9/25/2013. A toy cleaning schedule and checklist has been developed. Moving forward the toy cleaning schedule and checklist will be reviewed periodically at the Infection Control Committee meetings. Random visual inspections will be completed during Environment of Care rounding.</p>				

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	<p>soiled. 4. After each use, all toys that have been used in patient rooms or testing and treatment areas must be cleaned and disinfected..."</p> <p>c. under "Procedure for Cleaning and Disinfecting Toys", it reads: "1. Cleanse toy with soap and water using friction. Rinse with clean water and dry. 2. Thoroughly wipe toy with a hospital approved disinfectant or immerse in disinfectant solution...3. Rinse with water and dry."</p> <p>3. review of the policy and procedure (from the rehab services area) "Rehabilitation Division Standard Precautions", file number 49.30 with a most recent date of 8/11, indicated:</p> <p>a. in section "II. Precautions Guidelines A. Standard Precautions", in item 9., it reads: "Specified Therapeutic Activities...b. any equipment utilized will be placed in a labeled biohazard bin immediately after use and later cleaned with the appropriate cleaning disinfectant; allowed to air dry and then cleaned with soap and water prior to returning the item to service..."</p> <p>4. at 3:45 PM on 8/19/13, while on tour of the pediatric nursing unit in the company of staff member #62, the RN (registered nurse) nursing manager of</p>			

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	<p>peds, it was observed that:</p> <ul style="list-style-type: none"> a. a previous patient room (now an equipment storage room) had a sign on the door saying that all items in this room were clean b. soiled toys were located in a bathroom of this previous patient room, where clean equipment was located, inside plastic grocery-type bags awaiting cleaning/disinfecting c. a clean bedside commode was also in this bathroom where soiled toys are kept and cleaned <p>5. interview at 3:50 PM on 8/19/13 with staff member #62, the RN nursing manager of peds, indicated:</p> <ul style="list-style-type: none"> a. volunteers clean the toys b. the PDI disinfectant wipes are used to clean toys <p>6. interview with staff member #65, the infection control practitioner, at 1:00 PM on 8/20/13, indicated:</p> <ul style="list-style-type: none"> a. this staff member was unaware that there were three policies related to toy cleaning within the facility b. the three policies do not agree on the specifics of the toy cleaning process and the appropriate disinfectant to use c. there is a staff member (child life specialist) who is in charge of training volunteers in cleaning toys in the pediatric area 			
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S000606	<p>d. a schedule of the cleaning of toys weekly in the pediatric area was not available</p> <p>e. monitoring of toy cleaning has not been performed by the infection control/prevention practitioners/committee to ensure that the appropriate cleaning process is being utilized</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on policy and procedure review, contracted employee file review, and interview, the infection control committee failed to ensure that contracted staff met the same requirements for history of immunizations as employed staff for 1</p>	S000606	The Infection Control Practitioner will be meeting with the Supervisor of Employee Health Services to draft revisions to the current policy (HR 06.16) to include a process for non-immune employee's and contracted service employees. The draft will be presented to the	10/21/2013

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	<p>of 2 dialysis nurses (nurse N7).</p> <p>Findings:</p> <p>1. at 10:40 AM on 8/21/13, review of the policy and procedure "Health Services for Associates", HR 06.16, with a most recent date of 02/22/11, indicated:</p> <p>a. under section "II. Special Procedures", it reads: "...D...Rubella/Rubeola/Mumps Vaccine (MMR)/Varicella Vaccine is given if the associate is non-immune..."</p> <p>2. at 9:15 AM on 8/21/13, review of the files for contracted dialysis personnel indicated:</p> <p>a. RN (registered nurse) N7 was tested non-immune for mumps on July 2011 when first staffed at this facility</p> <p>b. the Mumps titer indicated a result of less than 0.91 (the reference note indicated <0.91 was non-immune)</p> <p>c. a note was hand written on the lab form to "inform" the employee of non-immunity</p> <p>d. there was no other documented follow up noted regarding the non-immunity to Mumps</p> <p>3. interview with staff member #70, the RN acute care manager of the contracted dialysis group, at 10:30 AM on 8/21/13, indicated their agency did not require</p>		Director of Human Resources to obtain approval from Administration. Clinical contract employees will be held to the same standards as payroll staff.				

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	<p>immunity to Mumps</p> <p>4. interview with staff member #67, the human resources manager, at 10:40 AM on 8/21/13, indicated:</p> <p>a. the non immune status of dialysis nurse N7 is not per facility policy and should have had action taken in 2011</p> <p>b. employee data of contracted agencies is not shared with human resources or occupational health to verify that all new hire requirements are met to the facility's satisfaction (only a check list of what they have in their files is given to human resources and it might read that a titer was drawn, but as in this case, it was drawn, but non immune with no follow up)</p>			

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S000608	<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 policy and procedure review, observation, and interview, the infection control committee failed to ensure the implementation of its policy related to OR (operating room) dress code regarding surgical masks.</p> <p>Findings: 1. at 8:45 AM on 8/20/13, review of the policy and procedure "O.R. Dress Code", policy number 4.02.04, with a most recent revised date of July 2010, indicated: a. under section "IV. Action Directives", it reads in item H. "Masks and eye Shields:", "...4] Masks will not be left dangling around the neck..."</p>	S000608	The Executive Director of Surgical Services will communicate to the Perioperative Staff and Endoscopy Staff the expectation of a change in behavior. Re-education on the current O.R. Dress Code policy (number 4.02.04) with an interdepartmental competency on the requirements. Monthly tracking of infractions will be monitored and reported back to the Executive Director of Surgical Services. Periodic observations by Infection Control and Quality Services will occur as well and any infractions will be reported to the Executive Director of Surgical Services.	09/25/2013			

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	<p>2. while on tour of the endoscopy north unit on 8/19/13 at 12:20 PM, in the company of staff member #53, the vice president and chief nursing officer, it was observed in the hallway near the post op area and exit, that one respiratory staff member was in the area with their surgical mask dangling about the neck</p> <p>3. on 8/21/13, between 11:35 AM and 12:30 PM, while on tour of the surgery area in the company of staff member #56, the surgery manager, it was observed that 8 different staff members were ambulating through out the various areas of surgery (not in operating suites) with their surgical masks dangling about the neck</p> <p>4. interview with staff member #56 at 12:15 PM on 8/21/13 indicated surgery staff were not to be walking about with their surgical masks dangling about the neck.</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 policy and procedure review, observation, patient medical record review, and interview, the nurse executive failed to ensure the implementation of policies by nursing</p>	S000912	S912, Items 1-3: Warming cabinet protocol was corrected the same day it was discovered. NICU staff reminded of the policy to date fluid bottles when placing them the proper fluid warmer with	09/20/2013			

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	<p>staff related to: fluids in warmers; pediatric assessment on admission and reassessment; and glucometer control solution expiration dates.</p> <p>Findings:</p> <p>1. review of the policy and procedure "Warming Cabinet Protocol...", policy number 1.20.25, with a last reviewed date of August 2012, indicated:</p> <p style="padding-left: 20px;">a. under section "V. Procedure", it reads: "...B. Fluid/Contrast Warmer 1) CONTRAST WARMER TEMPERATURE IS NOT TO EXCEED 98.6 DEGREES F. CONTRAST AND IV FLUID IS TO BE USED WITHIN TWO (2) WEEKS OF PLACEMENT IN WARMER..."</p> <p>2. while on tour of the NICU (neonatal intensive care unit) at 3:25 PM on 8/19/13, in the company of staff members #53, the vice president and chief nursing officer, and #71, the RN (registered nurse) manager of NICU, it was observed that 2 bottles of sterile water (200 ml each) and 2 bottles of sodium chloride (200 ml each) were found inside a blanket warmer and were not dated with an expiration date</p> <p>3. interview with staff member #71, the RN manager of NICU, indicated:</p> <p style="padding-left: 20px;">a. fluids are not to be placed in the</p>		<p>the 14 day expiration date. Staff also reminded that no fluids are to be placed in the blanket warmers at any time. NICU manager and charge nurses completing visual checks for compliance with both requirements.S912, Items 4-7: Obtaining Occipital-Frontal Circumference on pediatric patients 12 months or younger on admission and weekly has been reinforced with the pediatric nursing staff. An audit was completed the week of August 30th and found 100% compliance with measurement being completed per policy. Monthly audits will take place for 3 months to monitor for compliance with obtaining Occipital-Frontal Circumference on admission and weekly for all patients 12 months or younger. The Pediatric Nursing Manager will be responsible for monitoring the audit results.S912, Items 8-14: Glucometer control solutions being marked with expiration dates. Daily audits are being completed by all Nursing Managers for compliance with dating all glucometer control solutions. The audit results are being reported to Nursing Administration monthly. The daily audit began 9/20/13.</p>		

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	<p>blanket warmers (there are special warmers for fluids at a different temperature requirement)</p> <p>b. fluids placed in warmers are to be dated with 14 day expiration dates</p> <p>4. at 4:15 PM on 8/19/13, review of the policy and procedure "Admission to Pediatric Unit", policy number 6.27.02 with a most recent revised date of May 2011, indicated:</p> <p>a. under section "III. Procedure", it reads in item D.3.: "...a) Weigh patient...and obtain Occipital-Frontal Circumference if (12) months of age or under. An occipital-frontal circumference must be obtained by RN or LPN..." (licensed practical nurse)</p> <p>5. at 4:15 PM on 8/19/13, review of the policy and procedure "Measuring Occipital-Frontal Circumference", policy number 6.27.07, with a most recent reviewed date of May 2011, indicated:</p> <p>a. under section "I. Position/Policy Statement", it reads: "A. the Occipital-Frontal Circumference will be measured on <u>ALL</u> children twelve (12) months of age and under on admission. B. The Occipital-Frontal Circumference will be measured every Monday on <u>ALL</u> children aged twelve (12) months and under..."</p>			

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	<p>6. while on tour of the pediatric nursing unit at 3:40 PM on 8/19/13, in the company of staff members #53, the vice president and chief nursing officer, and #62, the RN pediatric nursing unit manager, it was noted in open medical record review, that:</p> <p>a. pt.#5 was admitted on 8/8/13 (Thursday) and lacked both an admission head circumference (occipital-frontal measurement) and a Monday measurement on 8/12/13, as required by facility policy</p> <p>7. interview with staff member #62, the RN pediatric nursing unit manager, at 3:55 PM on 8/19/13, indicated:</p> <p>a. it was thought that head circumference measurements only needed to be done on children with head injuries</p> <p>8. at 8:45 AM on 8/20/13, review of the policy and procedure "Nova Statstrip Whole Blood Glucose Monitoring System", policy number 1.02.44, with a last revised date of March 2013, indicated:</p> <p>a. under section "VI. Equipment/Material/Reagents:", in item C., it reads: "...1. StatStrip Glucose Test Strips 2. StatStrip glucose Control Solutions...3. Storage and</p>			

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	<p>Handling:...Opened Statstrip Control vials may be used for three (3) months after opening. <u>THE OPENED EXPIRATION DATE MUST BE RECORDED ON THE VIALS...</u></p> <p>9. while on tour of the endoscopy north unit on 8/19/13 at 11:40 AM in the company of staff members #53, the vice president and chief nursing officer, and # 56, the surgery manager, it was observed that:</p> <p>a. the glucometer control solutions #1 and #3 had notation on the vials indicating an expiration date of 8/2/13</p> <p>10. interview at 11:45 AM on 8/19/13 with staff member # 56, the surgery manager, indicated:</p> <p>a. the control solutions had expired b. there are 3 different sets of control solutions on this unit and this set of controls is rarely used</p> <p>11. while on tour of the CVIC (cardio vascular intensive care) unit at 10:50 AM on 8/20/13, in the company of staff member #60, the CVIC nurse manager, it was observed that:</p> <p>a. the glucometer control solution vial #3 was not dated with an opened or discard date</p> <p>12. interview with staff member #60,</p>			

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	<p>the CVIC nurse manager, at 10:55 AM on 8/20/13 indicated:</p> <p>a. it cannot be determined what the 3 month expiration date is for the control solution without notation of opened/discard dates</p> <p>13. while on tour of the ED (emergency department) at 12:55 PM on 8/19/13, while in the company of staff members #53, the vice president and chief nursing officer, and #56, the ED nurse manager, it was observed that:</p> <p>a. the glucometer control solution #1 was not dated with an opened or discard date</p> <p>14. interview with staff member #56, the ED nurse manager, at 1:00 PM on 8/19/13 indicated:</p> <p>a. it cannot be determined what the 3 month expiration date is for the control solution without notation of opened/discard dates</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 observation and interview, the facility failed to follow its policy/procedure and perform preventive maintenance (PM) on all electrical equipment for 6 items in one department.</p> <p>Findings:</p> <p>1. The administrative memorandum [policy] Electrical Safety (approved 7-06) indicated the following: " An electrical safety inspection shall be conducted on all electrically powered non-medical equipment intended to be used in designated high-risk areas prior to initial use, after repair or modification, and whenever an electrical safety problem is suspected ...[and]</p>	S001162	The Director of Environmental Services will obtain quarterly reports from the vendor that provides the preventative maintenance to the floor scrubbing equipment. All floor scrubbing equipment is in the process of being tagged with an identification number for tracking of preventative maintenance. Implementation of daily safety checks, on all electrical equipment utilized by environmental services, is in the process of being developed as well and will be reported to the Director of Environmental Services.	09/20/2013	

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	<p>...Operational Definitions ...<i>High-Risk Areas</i>...The following areas are classified as high-risk ...housekeeping areas ...</p> <p>2. On 8-19-13 at 1050 hours, staff A2 and A3 were requested to provide documentation of PM for floor scrubbing equipment and none was provided prior to exit.</p> <p>3. During a tour on 8-20-13 at 1640 hours in the main environmental services equipment room, 3 Rotoscrubber HP 175 rpm floor buffers, 2 Hand Burnisher HP 175 rpm floor finishers and 1 Hand Floor Scrubber HP 175 rpm floor buffer were observed without evidence of electrical safety checks or recent PM.</p> <p>4. During an interview on 8-20-13 at 1640 hours, staff A14 confirmed that the 6 floor scrubbers lacked evidence of electrical safety checks or recent PM.</p> <p>5. During an interview on 8-21-13 at 1015 hours, staff A9 confirmed that no documentation of electrical safety checks or PM was available for the 6 equipment.</p>			

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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 ensure that all equipment had evidence of preventive maintenance (PM) for 4 wheelchairs available for use if needed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a tour on 8-20-13 at 1040 hours, in the main entrance alcove, 4 wheelchairs were observed without evidence of periodic PM. 2. During an interview on 8-20-13 at 1040 hours, staff A9 confirmed that the wheelchairs lacked evidence of PM. 3. On 8-21-13 at 1045 hours, staff A11 was requested to provide documentation of PM for wheelchairs at the facility and none was provided prior to exit. 	S001164	<p>At the time of survey, the surveyor did not have access to all safety policies in place for the hospital. Policy EC.02.04.01.3.c (Medical Equipment Inclusion Policy) provides a risk based analysis for inclusion in a scheduled preventative maintenance (PM) program. According to this policy, wheelchairs have a risk score of 6.33 which requires "Annual environmental rounds inspection. This equipment has no major PM required and is documented as a minor PM." Currently, all staff members and volunteers are trained upon hire and annually on equipment safety and to watch for equipment in need of repair. Should equipment need repair a work order must be entered and the equipment is to be taken out of service. Environment of Care rounds are completed semiannually where patients are served and annually</p>	09/24/2013			

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	4. During an interview on 8-21-13 at 1410 hours, staff A3 confirmed that the facility wheelchairs were not receiving periodic PM to ensure safe use by patients, visitors and hospital personnel.		where patients are not served and any equipment identified as needing repair is taken out of service and sent to maintenance or biomedical engineering for repair (whichever is appropriate for the equipment). A work order is entered into the electronic building maintenance system and tracked until repair completion. A secondary line of review occurs daily with our volunteer members who clean the wheelchairs and also send them for repair when needed. The work order process is also used for this secondary process. The Director of Environment of Care has oversight of the Environment of Care rounding reports and monitors for compliance with policy EC.02.04.01.3.c.	

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S001318	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C)(D)(E)(F)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the implementation of its policy related to transfer form completion for 3 of 4 patients transferred to other acute care facilities from the ED (emergency department) and from medical surgical nursing units (pts.#11, #13, and #14).</p> <p>Findings: 1. review of the policy and procedure "Transferring Patient To Another</p>	S001318	Policy (1.01.08) review took place immediately after survey and has been updated to include keeping the original copy of the "External Transfer Authorization" form on the chart as part of the permanent medical record This change in policy will be in effect as of 9/26/2013. Audits will be conducted and monitored by Nursing Administration for compliance with this policy change.	09/26/2013			

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	<p>Facility...", policy number 1.01.08, with a last revised date of May 2012, indicated:</p> <p>a. on page one under section "II. Necessary Equipment", it reads: "...F. External Transfer Authorization" (Optio #1587)</p> <p>b. on page two under section "IV. Documentation", it reads: "...G. Original copy of External Transfer Authorization (Optio #1587) is part of the medical record (see attached form)..."</p> <p>c. the attached form lists a form number of 1600-0001-219 with a revision date of 06/24/08 and is titled "Transfer Form"</p> <p>2. at 1:05 PM on 8/21/13, review of transfer records with staff member #52, the director of nursing, indicated:</p> <p>a. pt. #11 was transferred from the ED to another facility on 6/1/13, and lacks completion of the Transfer Form in the are for the physician to complete and sign (sections IV. and V.)</p> <p>b. pt. #13 was transferred from med/surg 4B to an acute care facility in Indianapolis on 8/8/13 and lacked a transfer form in the medical record</p> <p>c. pt. #14 was transferred from med/surg 4C to another acute care facility in Indianapolis on 8/9/13 and lacked a transfer form in the medical</p>			

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	<p>record</p> <p>3. interview with staff member #52, the director of nursing, at 1:50 PM on 8/21/13, indicated:</p> <p>a. a phone call to medical records indicated they could not find copies of transfer forms for pts. #13 and #14, either</p> <p>b. transfer forms (a 1600 numbered facility document) should have been completed for these patients at the time of transfer to indicate physician contact with a receiving physician and patient/family consent to transfer</p> <p>c. the receiving hospitals and ambulance service will be contacted to see if the forms were completed and sent with the patient leaving no copies in the facility record</p> <p>d. the physician failed to complete pertinent sections (IV. and V.) of the transfer form for pt. #11</p> <p>(per e-mails with staff member #52 on 8/23/13: a. no transfer forms can be found for patients #13 and #14 from any other facility or agency b. form 1587 equals the transfer form 1600)</p>				