

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/15/2012
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH MORGAN HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 JOHN R WOODEN DR MARTINSVILLE, IN 46151
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005036</p> <p>Survey Date: 8-13/15-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 08/20/12</p>	S0000	The responses are contained within each tag #	

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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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 3 directly-provided services and 1 contracted service.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2011 indicated they did not include review of reports for the directly-provided central sterile supply, radiation therapy and transcription services.</p> <p>2. In interview, on 8-15-12 at 1:30 pm, employee #A4 indicated no report for the above directly-provided services was reviewed by the governing board in calendar year</p>	S0270	<p><b>Tag# S 270</b></p> <p><b><u>How deficiency will be corrected</u></b> Currently collected PI data for central sterile supply, radiation therapy, transcription services and contracted blood bank services will be reported to the governing board through the hospitals Clinical Performance Improvement Committee</p> <p><b><u>Future Prevention of Deficiency</u></b> Identified new directly-provided and contracted services will provide PI data quarterly to the hospitals Clinical Performance Improvement Committee (CPIC) for review. CPIC minutes will be reviewed at least quarterly by the hospitals governing board.</p> <p><b><u>Responsible</u></b> Chief Quality Officer, Radiology/Oncology Manager,</p>	08/22/2012
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	<p>2011 and no further documentation was provided prior to exit.</p> <p>3. Review of the governing board minutes for calendar year 2011 indicated they did not include review of reports for the contracted blood bank service.</p> <p>4. In interview, on 8-15-12 at 1:30 pm, employee #A2 indicated no report for the contracted blood bank service was reviewed by the governing board in calendar year 2011 and no further documentation was provided prior to exit.</p>		<p>Health Information Services Director, Lab Director <b><u>Date Corrected</u></b> 8/22/12</p>		

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S0322	<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:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on review of documents and interview, the hospital failed to have policies and procedures reviewed at least triennially in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's Safety Policy &amp; Procedure Manual indicated it was last approved 12-1-2008.</li> <li>2. In interview, on 8-14-12, employee #A2 indicated there was no more recent review of the entire manual and no further documentation was provided prior to exit.</li> </ol>	S0322	<p><b>Tag# S 322</b></p> <p><b><u>How deficiency will be corrected</u></b> Facility Safety Policy and Procedure Manual was reviewed by the hospitals Safety Committee.</p> <p><b><u>Future Prevention of Deficiency</u></b> Safety Committee chair will track the review dates of the Safety Policy and Procedure Manual for review by the hospitals Safety Committee at least triennially.</p> <p><b><u>Responsible</u></b> Safety Committee chair</p> <p><b><u>Date Corrected</u></b> 8/21/12</p>	08/21/2012	

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S0566	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (e)(1)(2)</p> <p>(e) The chief executive officer, medical staff, and executive nurse shall do the following:</p> <p>(1) Be responsible for the implementation of successful corrective action plans in affected problem areas.</p> <p>(2) Provide for appropriate infection control input into plans for renovation and new construction to ensure awareness of federal, state, and local rules that affect infection control practices as well as plan for appropriate protection of patients and employees during construction or renovation.</p> <p>Based on document review and interview, the facility failed to have an effective hospital-wide infection control program in relation to hand hygiene for one (Radiology Department) of eight departments monitored in the hand hygiene surveillance program.</p> <p>Findings included:</p> <p>1. On March 16, 2011, the infection control committee meeting minutes identified failure of the Radiology Department to attain the 90% compliance rate established by the Infection Control Committee for hand hygiene. The</p>	S0566	<p><b>Tag# S 566</b></p> <p><u>How deficiency will be corrected</u> On 8/22/12, the Infection Control Committee met and:</p> <p>1) Organized a sub-committee task force to review and make recommendations for improvement regarding the low rate of hand washing in the Radiology Department. The sub-committee will contain at least two lean six-sigma trained green belts. This sub-committee shall report back to the main Infection Control Committee all activities and progress made towards the improvement of hand</p>	08/29/2012			

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	<p>committee meeting minutes noted that any department which falls below the 90% must submit a plan of action.</p> <p>2. On June 15, 2011, the Infection Control Committee noted that the Radiology Department had not yet reached the 90% compliance goal. The minutes lacked documentation that the committee had directed the Radiology Department to submit a plan of action.</p> <p>3. On September 21, 2011, the Committee meeting minutes noted an overall hospital-wide hand hygiene compliance of 97.85% and noted a task force to include the Infection Control Officer and the Radiology Manager would be initiated to address the hand hygiene issue identified in the Radiology Department.</p> <p>4. On January 4, 2012, Hand Hygiene Surveillance Report was enumerated in the minutes of the meeting as a "Standard Business" item, but the minutes lacked any discussion or recommendations related to the continued non-attainment of the hand hygiene goal for the Radiology Department (80% in November, 2011 and 60% in December 2011- data obtained from the Infection Control Officer but not noted in the minutes). Under "New Business" it was noted in the meeting</p>		<p>hygiene in the Radiology Department.</p> <p>2) Directed the Director of Radiology to provide a written action plan (submitted 8/29/12) delineating intra-departmental actions and activities taken to improve the Radiology Departments hand hygiene percentages. Progress will be documented and reported at each Infection Control Committee meeting. Lack of progress in achieving the required goal will require additional action plans to be submitted.</p> <p><b><u>Future Prevention of Deficiency</u></b> Infection Control Committee will review all data submitted and implement corrective action plans to address low performing areas of concern. Data will be collected relating to the corrective action and the corrective action will be modified until a positive correction in performance is achieved.</p> <p><b><u>Responsible</u></b> Infection Control chair, Infection Control Committee, Radiology Director</p> <p><b><u>Date Corrected</u></b> 8/29/12</p>				

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	<p>minutes that IU Health's new hand hygiene program would begin in March 2012, but the minutes lacked documentation of discussion and recommendations related to how the Infection Control Committee would use the new program to address the ongoing non-compliance of the Radiology Department with the hand hygiene compliance goal.</p> <p>5. On March 21, 2012, Hand Hygiene Surveillance Report was enumerated as a "Standard Business" item in the minutes of the meeting, but the minutes lacked any discussion or recommendations related to the continued non-attainment of the hand hygiene goal for the Radiology Department (60% in January, 2012 and 60% in February 2012- data obtained from the Infection Control Officer but not noted in the minutes).</p> <p>6. During interview with S1 on August 15, 2012 at 10:15 AM, S1: a. stated S1 is the Infection Control Officer of the facility. b. verified the Infection Control Meeting Minutes data and the findings. c. verified that the compliance rates reported for the Radiology Department were: 60% in March, 2011 and stayed at 60% until the present with the exception of November 2011- 80% and June 2012-</p>			

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	<p>50%.</p> <p>d. verified the Infection Control Meeting minutes contained a compliance rate reported at the meeting from the Radiology Department only in March 2011. Other Infection Control Meeting minutes (June 15, 2011, September 21, 2011, January 4, 2012, and March 21, 2012) noted the hand hygiene problem in Radiology but lacked reporting or discussion of the data obtained from the surveillance tools regarding the Radiology Department for the Committees' recommendation.</p> <p>e. verified the hand hygiene assessment tool only monitored radiology technicians but that a Radiologist performs direct patient care in the department.</p> <p>f. verified that the Radiology Department Hand Hygiene Surveillance data showed that in over 15 months of data submitted to the Infection Control Officer, the Radiology Department had not attained the established compliance goal and that the data was not recorded in the Infection Control Committee meeting minutes except for March 2011.</p> <p>g. verified the Infection Control Committee had not consistently reviewed the surveillance data from the Radiology Department; had not requested that the Radiology Department submit a plan of action to the committee; had identified a problem with hand hygiene in the</p>			

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	<p>Radiology Department but failed to consistently review outcomes or assure resolution of the problem. The Infection Control Committee had not analyzed the Radiology Hand Hygiene data to determine if a pattern existed related to the consistently low compliance rates.</p> <p>h. verified that in September 2011 the minutes indicated the initiation of a task force to address the non-compliance in hand hygiene in the Radiology Department, but that the committee had not been appointed nor had any meetings been held.</p> <p>i. stated that the measures to improve hand hygiene in the Radiology Department had not resolved the hand hygiene problem.</p> <p>j. stated the hand hygiene data for August 2012 from the Radiology Department had not yet been received.</p> <p>7. During interview with S2 on August 15, 2012 at 12:05 PM, S2:</p> <p>a. stated S2 is the Manager of the Radiology Department, is a member of the Infection Control Committee, and regularly attends meetings.</p> <p>b. stated that S2 is aware of the non-compliance with the hand hygiene goal of 90% and is aware that the department has consistently fallen below</p>			

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	<p>the established compliance goal.</p> <p>c. stated S2 has taken measures in conjunction with input from the infection control officer related to hand hygiene of placing additional alcohol based sanitizers in the Radiology Department, placing signage to remind direct caregivers of correct hand hygiene, and sending a batch email to radiology technicians in 2011 containing a PDF presentation on hand hygiene; but that none of the measures had increased compliance or shown a trend of improvement with hand hygiene; therefore, none of the measures were effective.</p> <p>d. stated that the Infection Control Committee had not appointed a task force including S2 to focus on corrective measures to improve outcomes and assure resolution of the hand hygiene problem identified in the Radiology Department.</p> <p>e. stated that Radiologists in the department provide direct patient care but are not included in the hand hygiene observation forms for the Radiology Department.</p> <p>8. During interview with S3 on August 15, 2012 at 12:10 PM, S3 stated:</p> <p>a. S3 is a radiology technician and is responsible for performing observation and reporting data of the hand hygiene monitor to the Infection Control Officer.</p> <p>b. that S3 is aware of the non-compliance</p>			

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	with the hand hygiene goal of 90% and has reviewed the data from the last 15 months but has been unable to determine a pattern which explains the data. c. S3 has assisted in implementing measures in the department to improve hand hygiene compliance, but that none of the measures had increased compliance or shown a trend of improvement with hand hygiene; therefore, the measures were not effective			

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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on document review and interview, the facility failed to implement its "Pain Assessment and Pain Management" policy for 2 of 3 transfer medical records from the Emergency Department reviewed.</p> <p>Findings included:</p> <p>1. Facility policy " Pain Assessment &amp; Pain Management " , last reviewed/revised 1/2012, provided on page 2, " Reassessment and documentation of post-intervention effectiveness are dependent on type of intervention used. Reassessment should be evaluated as appropriate " .</p> <p>2. Review of N1 ' s medical record on 8-15-2012 indicated:</p> <p>a. N1 reported pain of 9 on scale of 0-10 on 8-2-2012 at 2:24 PM.</p> <p>b. Hydromorphone 1 mg was administered intravenously to N1 at 2:26 PM.</p> <p>c. the medical record lacked documentation of a post-intervention pain</p>	S0930	<p><b>Tag# S 930</b> <b><u>How deficiency will be corrected</u></b> The Patient Care Services pain medication and management policy will be revised by the Chief Nursing Officer to reflect best practice standards. Hospital wide education of the revised policy will be disseminated in all clinical areas. The hospitals EMR has been configured to display a visual queue to alert nursing staff of required post-administration reassessments. <b><u>Future Prevention of Deficiency</u></b> Nursing managers or their designee will periodically review missed reassessment reports and provide staff education as required. <b><u>Responsible</u></b> Chief Nursing Officer, Emergency Department Manager <b><u>Date Corrected</u></b> 9/12/12</p>	09/12/2012	

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	<p>assessment as required by facility policy.</p> <p>3. Review of N3 ' s medical record on 8-15-2012 indicated:</p> <p>a. N3 reported pain of 10 on scale of 0-10 on 8-4-2012 at 3:53 PM.</p> <p>b. Hydromorphone 0.5 mg was administered intravenously to N3at 4:50 PM.</p> <p>c. the medical record lacked documentation of a post-intervention pain assessment as required by facility policy.</p> <p>4. During interview with S4 on 8-15-2012 at 1:15 PM, S4:</p> <p>a. confirmed the findings in the medical records to include the lack of documentation of complete post-intervention pain assessments as per facility policy in findings 2 and 3 above.</p> <p>b. stated that the facility's expectation is that post-pain intervention assesement following administration of intravenous medication should occur within 15-30 minutes and include the patient ' s rating of pain level and a determination if the intervention was effective.</p>			

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S1150	<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, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.</p> <p>Findings:</p> <p>1. On 8-13-12 at 12:25 pm in the presence of employee #A5, it was observed in the Pathology Lab, there was a flexible hose connected to a water spigot above a sink without a backflow prevention device.</p>	S1150	<p><b>Tag# S1150</b> <b><u>How deficiency will be corrected</u></b> Lab sink flexible hose fitted with vacuum breaker backflow prevention device. <b><u>Future Prevention of Deficiency</u></b> Future installations of this type will include the required backflow prevention device as required by current Indiana plumbing code. <b><u>Responsible</u></b> Director of Plant Operations <b><u>Date Corrected</u></b> 8/17/12</p>	08/17/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the hospital failed to provide policies or manufacturer's recommendation describing preventive maintenance (PM) for 1 piece of equipment.</p> <p>Findings:</p> <p>1. On 8-15-12 at 10:20 am, employee #A5 was requested to provide policies or manufacturer's recommendation describing PM for a sleep study machine. The employee indicated there was none and no documentation was provided prior to exit.</p>	S1162	<p><b>Tag# S1162</b> <b><u>How deficiency will be corrected</u></b> Manufacturer contacted for recommended preventative maintenance schedule for sleep study machine. Documentation has been received and a preventive maintenance schedule is now in place as recommended by the manufacturer. <b><u>Future Prevention of Deficiency</u></b> Newly acquired equipment will be placed into tracking software according to manufacturer's recommendations/hospital policy as part of the routine receipt of new equipment to assure timely completion of preventative maintenance. <b><u>Responsible</u></b> Director of Plant Operations <b><u>Date Corrected</u></b></p>	08/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/15/2012
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S1164	<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. Based on document review and interview, the hospital failed to provide sufficient evidence of preventive maintenance (PM) for 4 pieces of equipment.</p> <p>Findings:</p> <p>1. Review of documents indicated there was insufficient documentation of PM on a blood warmer, lab centrifuge, overhead adjustable lights (operating room) and a sleep study machine.</p> <p>2. In interview, on 8-15-12 at 10:20 am, employee #A5 indicated there was no other documentation and none was provided prior to exit.</p>	S1164	<p>8/23/12</p> <p><b>Tag# S1164</b> <b><u>How deficiency will be corrected</u></b> Preventative maintenance will be completed on all identified equipment according to manufacturer's recommendations. <b><u>Future Prevention of Deficiency</u></b> Newly acquired equipment will be placed into tracking software according to manufacturer's recommendations/hospital policy as part of the routine receipt of new equipment to assure timely completion of preventative maintenance. <b><u>Responsible</u></b> Director of Plant Operations <b><u>Date Corrected</u></b> 8/23/12 – Surgical light 8/24/12 – Centrifuge 8/26/12 – Blood warmer 8/27/12 – Sleep study machine</p>	08/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150038		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/15/2012	
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S1197	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the hospital failed to have written documentation of a regular state or local fire inspection in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of documents indicated the last time a State or local inspection was conducted was on 11-1-10.</li> <li>2. In interview, on 8-15-12 at 10:15 am, employee #A5 indicated there was no further documentation of such an inspection within the last year, nor was there documentation the facility had requested a State or local fire inspection during the last year. No further documentation was provided prior to exit.</li> </ol>	S1197	<p><b>Tag# S1197</b> <b><u>How deficiency will be corrected</u></b> Local fire department contacted to provide fire inspection. <b><u>Future Prevention of Deficiency</u></b> Plant operation director to schedule fire inspection yearly with either the State or local fire marshal. <b><u>Responsible</u></b> Director of Plant Operations <b><u>Date Corrected</u></b> 8/22/12</p>	08/22/2012			