

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150048	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/15/2013
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NAME OF PROVIDER OR SUPPLIER REID HOSPITAL & HEALTH CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 REID PKWY RICHMOND, IN 47374
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005044</p> <p>Survey Date: 11-12/15-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 12/02/13</p>	S000000		

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

TITLE

(X6) DATE

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

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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR) for all health care workers, in accordance with hospital policy for 1 of 6 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled Procedural (Moderate/Deep) Sedation, section Reappointment, reviewed July, 2013, indicated among other requirements, all practitioners must be able to provide proof of maintained ACLS certification. Exception: Board Certified or Board</p>	S000318	The physician whom had let his ACLS recertification lapse will re-certify his ACLS. The next ACLS exam is January 24, 2014. The physician has been scheduled to attend class prior to exam date. The Manager of Medical Staff Services has added ACLS certification to the month expiration report. This will capture expiring certifications and allow for timely renewals to prevent this from occurring again. 11/15/2013-12/15/2013 - Physician will be scheduled to attend ACLS class. 12/16/2013-1/16/2014 - Physician will attend ACLS classes. 1/16/2014-1/24/2014 - Physician will complete ACLS competency check off.	01/24/2014			

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S000554	<p>Eligible physicians in Anesthesia, Cardiology, Emergency, Pulmonary/Critical Care medicine are except from having to obtain ACLS.</p> <p>2. Review of 6 medical staff credential files indicated file MD#3, a gastroenterologist endoscopist did not have any documentation of current ACLS certification.</p> <p>3. In interview, on 11-15-13 at 11:45 am, employee #A3 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and document review, the facility failed to store nutritional supplement according to the manufacturer's recommendation in 279 instances.</p> <p>Findings:</p>	S000554	<p>This deficiency was corrected by the following:1.) 11/13/13 nutritional supplement, in General Stores area, taken off the shelf and new reordered.2.) Upon receiving new supplies, these will be placed in enclosed boxes to avoid light.3.) Re-educated all store's staff by 11/21/13.4.) Policy</p>	11/21/2013
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	<p>1. On 11-13-13 at 11:35 am in the presence of employee #A2, it was observed in the General Stores area, there were the following stored on an open shelf, uncovered and unprotected, completely exposed to the light:</p> <p>56 2 oz. bottles Similac supplement 38 2 oz. bottles Similac special care 137 2 oz. bottles Similac advance 48 2 oz. bottles Similac expert care</p> <p>2. Review of the manufacturer's label on each bottle indicated [to] avoid exposure to light.</p> <p>3. Due to the prolonged exposure to light, the above items may have become ineffective.</p>		<p>revised and approved by the Infection Control Committee 12/10/13 as evidenced by attached Infection Control Committee minutes.5.) Materials Management (general stores) supervisor will monitor correction using environmental monitor form (attached) monthly and as needed and submit form to Infection Control department for review.</p>		

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S000612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on observation and document review, the hospital failed to follow its policy for the delivery and storage of linen in 3 instances.</p> <p>Findings:</p> <p>1. On 11-13-13 at 11:15 am, in the presence of employee #A2, it was observed in the General Stores area, there were 3 carts with linen on the top of the carts, awaiting delivery to patient care areas. The linen was uncovered and unprotected.</p> <p>2. Review of a facility document entitle LAUNDRY INFECTION CONTROL POLICIES AND PROCEDURES, section CLEAN LINEN STORAGE,</p>	S000612	<p>1.) The deficiency was corrected 11/19/13 by placing clean linen items in washable enclosed plastic bins.2.) 100% General Stores staff were re-educated 12/5/13 on corrected linen stocking process.3.) Linen policy approved 12/10/13 by Infection Control Committee (attached).4.) Materials Management (general stores) supervisor will monitor correction using environmental monitor form(attached) monthly and as needed and submit form to infection control department for review.</p>	12/10/2013			

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S000868	<p>approved July, 2013, indicated delivery and storage [of clean linen] should be in clean covered carts.</p> <p>3. Storage and delivery of clean, uncovered linen, subjected it to possible contamination.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed: (i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff; (ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or (iii) within forty-eight (48) hours after an admission.</p> <p>Based on document review and interview, the medical staff failed to ensure that a complete physical examination and medical history was performed on each patient admitted by a</p>	S000868	Surgery clerical staff will work with the physicians and their offices to ensure an H&P has been completed for all scheduled surgeries. (Clinical Director) 1/20/2014The Surgery clerical	01/20/2014			

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	<p>practitioner who has been granted such privileges by the medical staff within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission for 3 of 20 medical records (MR) reviewed (Patient #18, 20, 29 & 30).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Rules and Regulations indicated the following: "History & Physical Timeframe for Completion 1. Within 24 hours after admission 2. Within 30 days prior to admission with an admission note stating changes" The Medical Staff Rules and Regulations were last reviewed / revised on 11-15-11.</p> <p>2. Review of the following MRs indicated the following: Patient #18 was admitted to the facility on 09-25-13 and the History & Physical was completed on 09-27-13. Patient #20 was admitted to the facility on 07-03-13 and the History & Physical was completed on 06-13-13 and lacked documentation of an admission note stating changes. Patient #29 was admitted to the facility</p>		<p>staff will ensure an H&P is completed within 30 days prior to surgery. A stamp will then be placed on the H&P that is signed and dated by the physician with any updates to the patient's condition. (Clinical Director) 1/20/2014HIM Staff will review the content of the H&P to ensure the following components are included and meet documentation requirements for a valid H&P: Chief Complaint, History of Present Illness, Past History, Review of Systems, Physical Exam, Admitting Diagnosis, Psychosocial History, Family History, and Plan/Impression. (HIM Manager) 1/20/20147 days prior to surgery the surgical staff will ensure H&P's for all upcoming surgeries are on the chart. If an H&P is not present, two (2) attempts will be made to contact the physician to complete the H&P. (Clinical Director) 1/20/2014Two (2) days prior to surgery if an H&P is not present, the HIM Director and Clinical Director will be notified. (Clinical Director) 1/20/2014The morning of surgery if an H&P is not present, the surgery will not proceed until a valid H&P is available in the patient's chart. (Clinical Director) 1/20/2014Implement a hard stop on performing surgeries until there is an H&P on the chart. (Clinical Director) 1/20/2014Review Reid Policies and Procedures for needed</p>				

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	<p>on 09-12-13 and the History & Physical was completed on 09-11-13 and lacked documentation of an admission note stating changes.</p> <p>Patient #30 was admitted to the facility on 09-11-13 and the History & Physical was completed on 09-10-13 and lacked documentation of an admission note stating changes.</p> <p>3. On 11-15-13 at 1250 hours, staff #50 confirmed that patient #18, 20, 29 & 30's MRs lacked documentation of an admission note stating changes.</p>		<p>changes, with changes made as necessary. (Clinical Director & HIM Director) 12/16/2013 Educate surgeons on the importance of the H&P timeliness and content. Educate physicians on the cancel and reschedule procedure at the next Surgery Section meeting on 1/14/14. (HIM Director) 1/14/2014 Monthly Quality report results will be communicated with physicians in their staff meetings. (HIM Director) 3/1/2014 Surgery will produce a Monthly Quality report on the results of compliance with the completion and content of the H&P's. (OR Patient Safety & Quality Manager) Monthly HIM Committee to monitor compliance quarterly and perform random audits for compliance as part of their Clinical Pertinence. (HIM Director) Quarterly</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 document review and interview, the nurse executive failed to ensure that nursing staff followed established policy / procedures for assessment of obstetrical patients for 2</p>	S000912	1. Vitals Signs, Fundus and Locia checks every 15 minutes x4, every one-half hour x2 and then every 4 hours placed on chart audit for every Labor/Delivery Patient initiated on	11/15/2013			

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	<p>of 3 medical records (MR) reviewed (Patient #23 & 25).</p> <p>Findings include:</p> <p>1. Review of policy / procedure Standards of Patient Care Mother-Baby Care Center indicated the following: "Post Partum 1. To provide for the immediate care of the post partum patient. 2. Check vital signs, fundus and lochia every 15 minutes x 4, every one-half hour x 2 and then every 4 hours." This policy / procedure was last reviewed / revised on 02-02-11.</p> <p>2. Review of patient #23's MR indicated the patient delivered a baby on 09-15-13 at 1153 hours and placenta at 1156 hours. Patient #23's MR indicated the patient's vital signs were taken on 09-15-13 at 1211 hours, 1226 hours, 1241 hours and 1255 hours. Patient #23's MR lacked documentation of vital signs were checked every one-half hour x 2. Patient #23's MR indicated the patient's fundus and lochia were checked on 09-15-13 at 1230 hours, 1239 hours, 1256 hours, 1311 hours and 1328 hours. Patient #23's MR lacked documentation of patient's fundus and lochia were checked every one-half hour x 2.</p>		<p>11/15/2013.2. Chart Audits will continue for every Labor/Delivery patient and then Mother Baby Care Center Unit Manger will be responsible to maintain Chart Audits and will follow through with each staff member with Just Culture if deficiency is noted.4. Chart Audits initiated on 11/15/2013.</p>				

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S001164	<p>3. Review of patient #25's MR indicated the patient delivered a baby on 09-20-13 at 1244 hours and placenta delivered at 1254 hours. Patient #23's MR indicated the patient's vital signs were taken on 09-20-13 at 1317 hours, 1332 hours, 1241 hours and 1347 hours. Patient #25's MR lacked documentation of vital signs were checked every one-half hour x 2.</p> <p>4. On 11-15-13 at 0955 hours, staff #50 confirmed that patient #23 and 25's MR lacked documentation of vital signs being checked one half hour x 2 and patient #23's MR lacked documentation of fundal and lochia being checked one half hour x 2.</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 preventive maintenance on all equipment.</p>			

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	<p>Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 2 pieces of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 11-14-13 at 11:00 am, employee #A2 was requested to provide documentation of PM on a trapeze piece of equipment in the pediatric offsite rehabilitation area. On 11-14-13 at 11:05 am, employee #A2 was requested to provide documentation of PM on a zipline piece of equipment in the pediatric offsite rehabilitation gym. In interview, on 11-14-13 at 1:20 pm, employee #A2 indicated there was no documentation of the above pieces of equipment and none was provided prior to exit. 	S001164	<p>Preventive Maintenance had been completed on both pieces of equipment however the PM log was unable to be located. Log book was located on 11/15/13. Log book is now located in central location and is maintained by the Rehab Aides located at 2021 Chester Blvd. The Rehab Services Secretary/Aide Supervisor is responsible for the monthly PMs of the Pediatric swings/trapeze. Copies of the PMs are attached.</p>	11/15/2013	

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S001168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on observation and interview, the facility failed to ensure that defibrillators are discharged in accordance with manufacturer recommendations and a discharge log with initialed entries is maintained for 1 offsite.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 11-13-13 at 0920 hours during the tour of the ROC outpatient surgery area offsite, a Medtronic Lifepak AED was observed sitting next to the emergency crash cart. 2. On 11-13-13 at 0920 hours, staff #44 confirmed there was no discharge log for the Medtronic Lifepak AED. 	S001168	<p>The AED in question was brought into the ROC Surgery facility by a physician. The AED was removed from the facility immediately on 11/15/2013 therefore resolving the issue. On 12/11/2013 an email was sent to all ROC Surgery employees and physicians that utilize the facility stating that no equipment can be brought in from the outside. It will be the responsibility of the Medical Director, Business Director and Charge Nurses to ensure that no outside equipment comes into the facility.</p>	11/15/2013	