

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY 7TH FL E FORT WAYNE, IN 46802
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S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 009856 Survey Date: 04-18/20-2016 QA: cjl 05/27/16	S 0000		
S 0102 Bldg. 00	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 document review and interview, the facility failed to follow IC (Indiana Code) regarding a check of the nurse aide registry for 1 of 1 non certified nurse aides whose file was reviewed, staff member P4. Findings Include: 1. Review of IC 16-28-13-4, reads in Sec. 4. (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	S 0102	During the survey, it was discovered that for a nurse aide employeethe nurse aide registry had not been checked within 3 business days from thedate the person was employed as a nurse aide per Indiana Code 16-28-13-4. Thisemployee was hired prior to the start date of the current Human ResourcesCoordinator. An audit of all currently employed nurse aides was completedon 6/1/16 by the Human Resources Coordinator. The nurse aide registry has beenchecked for those who have certification and a printed copy of thecertification has been placed	06/01/2016

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>contracting to provide nurse aides or other unlicensed employees for a healthcare 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 5-2-5 or another source allowed by law.</p> <p>2. Review of the employee file for nurse aide P4 indicated they were hired 11/11/14 and had no documentation in their file of having the nurse aide registry checked within 3 days of hire, or at any other time.</p> <p>3. At 9:15 AM on 4/19/16 and 12:05 PM on 4/20/16, nterview with human resources, staff member #52, confirmed that:</p> <p>A. No nurse aide registry check could be found for P4.</p> <p>B. There is no policy related to doing nurse aide registry checks at the time of hire.</p> <p>C. It was unknown that the nurse aide registry needed to be checked for nurse aides who are not certified.</p>		<p>in the files of all nurse aides that arecertified but for whom the nurse aide registry was not previously checked. Fornurse aides that are not certified, primary source verification, referencechecks and background checks are to be in the employee file prior to hire.</p> <p>The current Human Resources Coordinator was re-educated onthe Select Medical Corporation Human Resources Policies and Procedures:Credentials Verification Policy which states, "At the time of hire, in additionto the primary source verification and in accordance with the state practiceact(s), the credential and/or a copy (unless state law prohibits such apractice) of the credential is placed in the employee's personnel file."</p> <p>To ensure ongoing compliance, the Human ResourcesCoordinator will audit new nurse aide employee files with the nurse aideregistry check for certified nursing assistants and all nurse aids will haveprimary source verification, reference checks and background checks in fileprior to hire.</p> <p>This corrective action was completed on 6/1/16.</p>	

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S 0270 Bldg. 00	<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 activities for 1 directly-provided service, 13 contracted services, and 1 other activity for calendar year 2015.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the governing board minutes for calendar year 2015, indicated they did not include review of reports for the directly-provided services of physical therapy. 2. Review of the governing board minutes for calendar year 2015, indicated they did not include review of reports for the contracted services of electrodiagnostic, outpatient surgery, 	S 0270	<p>A document review of quarterly reports showed that the governing board failed to review reports of quality activities for 1 directly provided service (defined as physical therapy), 13 contracted services (defined as electrodiagnostics, outpatient surgery, nuclear medicine, wound care, burn unit, IV therapy, Biotech Chemotherapy, biohazardous waste hauling, housekeeping microfiber cleaning, speech pathology, and bladder scanning), and 1 other activity (defined as reportable events).</p> <p>The Director of Rehab Therapy will be responsible to report on physical therapy services quarterly in the Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings. An ad</p>	06/27/2016

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	<p>cardiac cath, inpatient surgery, nuclear medicine, wound care, burn unit, IV Therapy, Biotech Chemotherapy, biohazardous waste hauling, housekeeping microfiber cleaning, speech pathology, and bladder scanning.</p> <p>3. Review of the governing board minutes for calendar year 2015, indicated they did not include review of reports for the other activity of reportable events.</p> <p>4. Interview of employee #A1, Director Quality Management, on 04-20-2016 at 10:50 am, confirmed all the above and no further documentation was provided prior to exit.</p>		<p>hocGoverning Board meeting will take place on or before 6/27/16 for physicaltherapy to report quality process improvement indicators for departmentservices. The Director of Quality Management will be responsible foradding the following 13 contracted activities: electrodiagnostic, outpatientsurgery, cardiac cath, inpatient surgery, nuclear medicine, wound care, burnunit, IV therapy, Biotech Chemotherapy, biohazardous waste hauling,housekeeping/Laundry (microfiber cleaning), speech pathology, and bladderscanning will be added to the contract matrix report with associated qualityindicators. Indicators for contracted activities will be reported quarterly inthe Organizational Improvement Committee, Medical Executive Committee, andGoverning Board meetings. An ad hoc Governing Board meeting will take place onor before 6/27/16 to report quality indicators for the above for contractedservices. The Director of Quality Management will be responsible toreport on reportable events by reviewing all incident reports, RCAs, complaintsand grievances quarterly in the Organizational Improvement Committee, MedicalExecutive Committee, and Governing Board meetings. An ad hoc Governing Boardmeeting that will take place on or before 6/27/16 to report on the</p>	

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S 0308 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the hospital failed to generally orient 4 of 4 contract employees, per facility policy.</p> <p>Findings include:</p> <p>1. Review of a facility policy entitled ORIENTATION - GENERAL,</p>	S 0308	<p>above reportable events.</p> <p>To ensure ongoing compliance, the CEO/Vice Chairperson and secretary of the Governing Board will ensure that all Governing Board meetings contain a report of physical therapy quality process improvement indicators, contracted services quality indicators and reportable events.</p> <p>This complete corrective action plan will be completed by 6/27/16.</p> <p>During the survey, it was discovered that 4 agency/contracted personnel files did not contain any documentation of general orientation. An audit of all current agency/contracted staff was completed on 6/1/16 by the Human Resources Coordinator, and for those files missing the Agency/Contract Staff Orientation</p>	06/01/2016

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S 0312 Bldg. 00	<p>approved 02-06-2016, indicated "Agency/Contract staff must complete an orientation process"</p> <p>2. Review of 4 contracted personnel files indicated files CP6, CP7, CP8, and CP9 did not contain any documentation of general orientation.</p> <p>3. Interview of employee #A5. Director Human Resources, on 04-20-2016 at 12:15 am, confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the</p>		<p>Checklist (Clinical), the Director of Quality Management completed the general orientation checklist with those agency/contracted staff, and the Human Resources Coordinator placed the record in the agency/contracted staff education file.</p> <p>To ensure ongoing compliance, the Agency/Contract Staff Orientation Checklist (Clinical) will be completed by the charge nurse, Chief Nurse Officer, or designee with the agency/contracted staff on first day of hospital orientation. The Human Resources Coordinator will audit all new agency/contract orientation files to ensure orientation is completed prior to filing in the agency/contracted staff employee education file and track completion of the orientation checklist on the Agency Tracking Grid. The Human Resources Coordinator will report to the Chief Nurse Officer any agency/contract employee that has not completed orientation to that the Chief Nurse Officer does not schedule a working shift until orientation is completed.</p> <p>This corrective action was completed on 6/1/16.</p>	

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	<p>following:</p> <p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the hospital failed to conduct performance reviews according to facility policy for 5 of 5 contracted employees.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled PERFORMANCE REVIEWS, last approved 02-06-2016, indicated "Performance reviews will be completed by the supervisor at the completion of the introductory period and annually within 30 days of the employee's anniversary date, or a designated date set by the Company."</p> <p>2. Review of 5 contracted personnel files indicated files P#6, P#7, P#8, P#9, and N6 did not contain any documentation of specific department orientation.</p>	S 0312	<p>A review of 5 contracted employee files showed that the hospital failed to conduct performance reviews according to facility policy. The Director of Quality Management and the Human Resources Coordinator completed an audit of the current contracted employee files to ensure performance reviews were completed. This was completed on 6/1/16.</p> <p>For those missing performance reviews, an immediate performance review was completed by the Chief Nurse Officer and placed in the contracted employee's file. The Chief Nurse Officer will ensure ongoing compliance by ensuring that all new agency/contracted employees will have an Employee Performance Review completed after the first shift worked and then annually if the contracted employee continues to work throughout the year. The Human Resources Coordinator will audit agency files during the</p>	06/01/2016

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S 0330 Bldg. 00	<p>3. Interview of employee #A5, Director Human Resources, confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review, observation and interview, the chief executive officer failed to ensure that personnel files contained properly documented post offer physicals for 4 of 12 nursing personnel (P1, P2, P3, N5).</p> <p>Findings Include:</p>	S 0330	<p>introductory period and annually to ensure performance reviews have been completed and will track completion of first shift and annual evaluations on the Agency Tracking Grid. This corrective action plan was completed as of 6/1/16.</p> <p>During the survey, it was discovered that there were 2 employee health screens not signed off by the Employee Health Nurse and 2 employees missing the employee health screen form altogether. All 4 employees were hired prior to the start of the current Human Resources Coordinator and Director of Quality Management, who also</p>	06/27/2016

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	<p>1. Review of policy/procedure IC X-2, Employee Screening: New Hire and ongoing, indicated on page 1 the following; PROCEDURE Pre-employment: A. All applicant health screens are reviewed by the Director of Quality Management (DQM), or designee. This policy/procedure was last reviewed/ revised on January 2016.</p> <p>2. Review of policy/procedure SELECT MEDICAL CORPORATION HUMAN RESOURCES POLICIES & PROCEDURES on page 1 indicated the following; SUBJECT: PHYSICAL SCREENINGS POLICY: All offers of employment for positions involving direct patient care/contact will be conditional pending successful completion of a physical screening, which may include drug testing, to establish that the employee is capable of performing the essential job functions with reasonable accommodations. This policy/ procedure was last reviewed/ revised on 1-1-99.</p> <p>3. Review of personnel files indicated that staff N5 and P2 lacked an Employee Health (EH) signature on page 2 of the health screening. P1 lacked documentation of a page 2 for the health</p>		<p>functions as the Employee Health Nurse. An audit of all employee health files will be conducted to ensure health screens are in the employee health file and signed by the Employee Health Nurse. For any employees lacking a complete Employee Health Nurse signed health screening, a new health screening form will be completed by the employee and reviewed and signed off by the current Employee Health Nurse. To ensure ongoing compliance, newly hired employees meet first with the Human Resources Coordinator to complete new hire paperwork and then with the Director of Quality Management/Employee Health nurse to complete the health screen form. The Director of Quality Management/Employee Health nurse will then sign the form to attest that it was reviewed and the Human Resources Coordinator will place the completed form in the employee health file. The Human Resources Coordinator will audit employee health files prior to first day of orientation to ensure health screening forms are completed and signed. This corrective action will be completed by 6/27/16.</p>		

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S 0406 Bldg. 00	<p>screening. P3 lacked documentation of an entire post offer health screening.</p> <p>4. On 4-20-16 at 1055 hours staff #51 confirmed the lack of documentation for a health screening for staff P3, the lack of a page 2 of the health screening for P1 and that the health screenings lacked an EH signature for N5 and P2.</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 hospital failed to include monitors and standards for 13 services provided by a contractor, and no standards for 1 directly-provided service, as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2015.</p>	S 0406	A document review of quarterly reports showed that the governing board failed to review reports of quality activities for 1 directly provided service (defined as physical therapy), 13 contracted services (defined as electrodiagnostics, outpatient surgery, nuclear medicine, wound care, burn unit, IV therapy, Biotech	06/27/2016

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	<p>Findings include:</p> <ol style="list-style-type: none"> Review of a document entitled <u>PROFESSIONAL SERVICES AGREEMENT</u>, between the facility and host hospital, HH#1, dated December 1, 1996, indicated HH#1, would provide contracted service to the facility, including electrodiagnostic services and outpatient surgery services. Review of an interoffice memorandum from the facility to HH#1, dated January 8, 1998, indicated HH#1 would provide the contracted services of cardiac cath and surgery (inpatient) to the facility. Review of a document entitled <u>PROFESSIONAL SERVICES AGREEMENT ADDENDUM</u>, dated July 1, 1998, indicated HH#1 would provide contracted services of nuclear medicine, wound care, burn unit, IV Therapy, and Biotech Chemotherapy to the facility. Review of the facility's QAPI program for calendar year 2015 indicated it did not include monitors and standards for the contracted services of electrodiagnostic, outpatient surgery, cardiac cath, inpatient surgery, nuclear medicine, wound care, 		<p>Chemotherapy, biohazardous waste hauling, housekeeping microfiber cleaning, speech pathology, and bladder scanning), and 1 other activity (defined as reportable events).</p> <p>The Director of Rehab Therapy will be responsible to report on physical therapy services quarterly in the Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings. An ad hoc Governing Board meeting will take place on or before 6/27/16 for physical therapy to report quality process improvement indicators for department services.</p> <p>The Director of Quality Management will be responsible for adding the following 13 contracted activities: electrodiagnostic, outpatient surgery, cardiac cath, inpatient surgery, nuclear medicine, wound care, burn unit, IV therapy, Biotech Chemotherapy, biohazardous waste hauling, housekeeping/Laundry (microfiber cleaning), speech pathology, and bladder scanning will be added to the contract matrix report with associated quality indicators. Indicators for contracted activities will be reported quarterly in the Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings. An ad hoc Governing Board meeting will take place on or before 6/27/16 to report</p>	

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S 0420 Bldg. 00	<p>burn unit, IV Therapy, Biotech Chemotherapy, biohazardous waste hauling, housekeeping microfiber cleaning, speech pathology, bladder scanning and no standards for the directly-provided service of physical therapy.</p> <p>5. In interview, employee #on 11-6-13 at 3:45 pm, employee #A1, Director Quality Management, confirmed all the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the hospital: (A) The following surgical events:</p>		<p>quality indicators for the above for contracted services.</p> <p>The Director of Quality Management will be responsible to report on reportable events by reviewing all incident reports, RCAs, complaints and grievances quarterly in the Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings. An ad hoc Governing Board meeting that will take place on or before 6/27/16 to report on the above reportable events.</p> <p>To ensure ongoing compliance, the Chief Executive Officer/Vice Chairperson and Secretary of the Governing Board will ensure that all Governing Board meetings contain a report of physical therapy quality process improvement indicators, contracted services quality indicators, and reportable events. This complete corrective action plan will be completed by 6/27/16.</p>	

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NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY 7TH FL E FORT WAYNE, IN 46802
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	<p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained. (CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p>			

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	<p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose;</p>			

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	<p>(CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy</p>			

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	<p>performed in the hospital.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital.</p> <p>Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the hospital.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p> <p>Based on document review and interview, the facility failed to include reportable events as part of its quality assessment and performance</p>	S 0420	Based on a document review, the facility failed to includereportable events as a part of its QAPI program for calendar year 2015. Duringa portion of 2015, the facility did not	05/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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S 0592 Bldg. 00	<p>improvement (QAPI) program for calendar year 2015.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include reportable events. 2. Interview of employee #A1, Director Quality Management, on 04-20-2016 at 10:50 am, confirmed the above and no documentation was provided prior to exit. <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</p>	S 0592	<p>have a DQM, and as a result, the QAPI meeting was not consistently held on a monthly basis. The Director of Quality Management delineated reportable events on the QAPI calendar under the RCA header.</p> <p>The Director of Quality Management will report RCAs and delineated reportable events in all monthly QAPI meetings. The Chief Executive Officer will review QAPI meeting minutes to ensure reportable events have been discussed. This corrective action plan is complete as of 5/25/16.</p> <p>The Infection Control Committee failed to ensure that the contracted housekeeping services'</p>	06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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	<p>committee failed to ensure that the contracted housekeeping facility cleaning products were approved for use, that housekeeping staff were aware of the dwell time for products used, and failed to ensure that floors were being disinfected as required per the facility policy related to bloodborne pathogens.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Review of the host hospital policy: "Chemical Solution Formula" for environmental services, indicated that for floor disinfecting, a product called Alpha-HP Disinfectant was to be used and that for "Floor scrubbing", a product called GP Forward Neutral Cleaner was to be used. 2. At 10:50 AM on 4/20/16, interview with the DQM (director of quality management)/infection supervisor, staff member #50, confirmed that the housekeeping list of cleaning products (from the contracted host hospital) had not been approved by the infection control committee. 3. Review of the policy IC III-5 Contact/Contact Enteric Precautions, revised April 2013, indicated in section B. Specific Procedures:....17. "Terminal disinfection - Usual cleaning of room with a germicidal-detergent solution at 		<p>cleaning products were approved for use; that the housekeeping staff was aware of the dwell/kill time for products used; and that floors were being disinfected as required by policy.</p> <p>The Respiratory Therapy Supervisor verified on 6/2/16 with the host hospital's Environmental Services Manager that the floors are now being cleaned with a product containing a disinfectant per the facility's policy. The product being used is Diversey Alpha-HP which is included on the cleaning product list provided by the host hospital's Environmental Services Manager and that will be reviewed for approval. The cleaning product list will be presented for approval during an ad hoc Organizational Improvement Committee and Governing Board meeting that will take place on or before 6/27/16.</p> <p>The Respiratory Therapy Supervisor also verified with the host hospital's Environmental Services Manager on 6/3/16 that the housekeeping staff had been educated on the dwell/kill time for the products they use. To ensure ongoing compliance, the Materials Manager will be responsible for maintaining an inventory of cleaning products used by housekeeping. This information will be maintained by the Materials Manager on the Chemical Inventory Sheet. The Materials manager will inform the Organizational Improvement</p>	

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	<p>the time of the patient's discharge is adequate with the exception of patients with an enteric illness such as C-Diff/Norovirus in which case a bleach solution should be used...".</p> <p>4. Review of the policy IC XII-1, Bloodborne Pathogen Exposure Control Policy, last reviewed April 2013, indicated on page 6 in the section "IX. Housekeeping" that "1. All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials...".</p> <p>5. At 10:45 AM on 4/19/16, interview with the housekeeper on the 7th floor nursing unit, staff member #54, confirmed that:</p> <p>A. GP forward, a general purpose cleaner and not a disinfectant, was being used on all floors as the Alpha-HP product made the floors sticky.</p> <p>B. The GP forward product was used to clean "blood and other stains" on the floors.</p> <p>C. The Alpha-HP product, used to disinfect objects in patient rooms and high touch surfaces, had a 5 minute dwell/kill time.</p> <p>6. At 10:47 AM on 4/19/16, review of the label for the Alpha-HP product</p>		<p>Committee of any new products being used. Any potential new products need to be approved by the Organizational Improvement Committee and be reflected on the Chemical Inventory Sheet. Also, the housekeeping staffs' knowledge of dwell/kill times will be randomly assessed by the Respiratory Therapy Supervisor during monthly Environment of Care Rounds and by the Director of Quality Management during monthly infection Control Rounds.</p> <p>This corrective action plan will be completed by 6/27/16.</p>	

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	<p>indicated it had a 10 minute kill time to be effective in the disinfection of organisms.</p> <p>7. At 9:35 AM on 4/20/16, interview with the director of EVS (environmental services) at the host hospital, staff member #55, confirmed that:</p> <p>A. The Alpha-HP product was discontinued "about 2 weeks ago" due to making black marks on the floors.</p> <p>B. This staff member is working with their supplier to find a disinfectant that works without causing stickiness and black marks to floors, so currently, only a general purpose cleaner is being used on floors, even with terminal cleaning of patients who have been in isolation/precautions.</p> <p>C. It cannot be determined when EVS staff enter a room to clean floors whether or not blood and body fluids had been disinfected properly so that disinfection should be completed by EVS staff.</p> <p>D. The cleaning products on the "Chemical Solution Formula" policy have not been presented to the infection control committee at this facility for approval.</p> <p>8. At 10:50 AM on 4/20/16, interview with the DQM/infection supervisor, staff member #50, confirmed that:</p>			

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NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY 7TH FL E FORT WAYNE, IN 46802
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S 0596 Bldg. 00	<p>A. It was unknown to this staff member that EVS staff were no longer disinfecting floors.</p> <p>B. It cannot be determined when EVS staff enter a room to clean floors whether or not blood and body fluids had been disinfected properly so that disinfection should be completed by EVS staff.</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 observation and interview, the infection control committee failed to monitor sterilization processes of the contract facility in the reprocessing of RT (respiratory therapy) instruments.</p> <p>Findings Include; 1. At 9:55 AM on 4/19/16, while on tour</p>	S 0596	The Infection Control Committee failed to monitorsterilization processes of the contract facility in the reprocessing of respiratorytherapy instruments. The Respiratory Therapy Supervisor contacted the hosthospital's Central Supply Manager regarding the host hospital forwarding thebiological	06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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S 0606 Bldg. 00	<p>of the soiled utility on the 7th floor nursing unit in the company of RN (registered nurse) #53, it was observed that RT used/soiled instruments were held in a tub to be transported to the host hospital's central sterile area for reprocessing/sterilization.</p> <p>2. At 10:20 AM on 4/20/16, interview with the director of RT services, staff member #56, confirmed that the host hospital was contracted to reprocess/sterilize soiled RT instruments.</p> <p>3. At 10:50 AM on 4/20/16, interview with the DQM (director of quality management) and infection control supervisor, #50, confirmed that the infection control committee is not currently monitoring the sterilization processes of the host hospital in reprocessing instruments for this facility.</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</p>		<p>report for sterilization loads containing our respiratory therapyequipment. The Respiratory Therapy Supervisor educated the respiratorytherapy staff to forward the biological sterilization reports to the Directorof Quality Management/Infection Control Nurse each time the respiratoryequipment is picked up. This education was completed on 6/3/16. The Director of Quality Management will add thesterilization of respiratory equipment to the quarterly contract matrix reportfor review during the quarterly Organizational Improvement Committee, MedicalExecutive Committee, and Governing Board meetings. The load pass/failbiological report will be the quality indicator to be measured and reviewed forthis report. The biological reports will be reviewed during an ad hoc OrganizationalImprovement Committee and Governing Board meeting that will take place on orbefore 6/27/16.</p> <p>This corrective action will be completed on 6/27/16.</p>	

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	<p>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.</p> <p>Based on document review and interview, the employee health nurse failed to ensure the implementation of facility policy related to new hire immunization status for 3 of 4 non contract RNs (registered nurses), staff members P1, P2, and P3, and for 1 of 2 agency RNs, N3.</p> <p>Findings Include: 1. Review of the policy IC X-2, Employee Screening: New Hire and Ongoing, last revised January 2016, indicated under "Procedure", in section F.: The health screen will consist of the following:...4. TB (tuberculosis) Assessment; a. A two-step tuberculin skin test will be performed,...5. Immunization records: a. Proof of measles and mumps and rubella immunity is only required, if required by the state...c. Hepatitis B...i. The</p>	S 0606	<p>During the survey, a review of employee health files showed that the facility's policy related to new hire immunization status had failed to be implemented on 3 of 4 non contract RNs, 3 other staff members, and 1 of 2 agency RNs. The Director of Quality Management/Employee Health Nurse will be responsible to audit all current agency contracted staff and employee health files to ensure that they all consist of the following: a TB (tuberculosis) assessment; A two-step tuberculin skin test; immunization records showing proof of measles, mumps, and rubella immunity as required by state; a hepatitis B notification form with a signed declination or authorization section; dates of hepatitis B vaccine series for those who have previously received the vaccine; and documentation of the hepatitis B vaccine initiated within 10 days of initial assignment if authorization</p>	06/27/2016

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	<p>applicant reads and completes the Hepatitis B Notification form. ii. The declination or authorization section is signed. iii. Dates of Hepatitis B vaccine series are requested from all applicants who have previously received the vaccine...iv. If vaccination is authorized the series will be initiated within 10 days of initial assignment...".</p> <p>2. Review of employee files indicated:</p> <p>A. RN P1 (hired 3/23/07) did not have a declination or authorization form for Hepatitis B, or any indication of previous completion of the Hepatitis B series.</p> <p>B. RN P2 had:</p> <p>a. Documented on the health history screening form a self reported history of disease for Varicella, but the form was not confirmed by a physician or mid-level practitioner.</p> <p>b. Requested the Hepatitis B series at the time of hire in October 2015, but had no documentation to show that the series had been provided.</p> <p>C. RN P3 (hired 2/18/15) had no documentation in the employee file for a TB test (two step required at hire), for Rubella, Rubeola, Varicella, or Hepatitis B.</p> <p>D. Agency RN N3 lacked any documentation related to Rubella, Rubeola and Varicella.</p>		<p>completed. Deficiencies noted during the audit regarding missing documentation of the following: declination/authorization form for Hepatitis B or any indication of previous completion of the Hepatitis B series; state required immunization records; and TB test (two-step that is required at hire will be addressed as identified during the audit.</p> <p>To ensure ongoing compliance, the Director of Quality Management/Employee Health Nurse will audit all new employee and agency/contracted staff health files for completion prior to hire and annually that they contain the following: Employee Health Nurse signed Health Screening, Hepatitis B declination/authorization form, TB two-step test on hire, drug screen, latex allergy screening, respirator fit test, report of communicable disease screening, exposure category screening, and state required immunizations. If non-compliance is noted, the Director of Quality Management/Employee Health Nurse will complete the deficient items with that employee or agency/contracted staff. This corrective action will be completed by 6/27/16.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY 7TH FL E FORT WAYNE, IN 46802
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S 0612 Bldg. 00	<p>3. At 10:55 AM on 4/20/16, interview with human resources, staff member #52, confirmed that employee P2 had signed in October 2015 requesting the Hepatitis B series, but it had never been provided to the staff member.</p> <p>4. At 11:25 AM on 4/20/16, staff member #52 confirmed that:</p> <p>A. Staff member P1 lacked an authorization or declination form in the employee file for Hepatitis B.</p> <p>B. The agency representative for RN N3 stated that they do not require immunization status for their staff.</p> <p>5. At 12:34 PM on 4/20/16, staff member #52 confirmed that no TB test, Rubella, Rubeola, Varicella, or Hepatitis B documentation could be found for RN P3.</p> <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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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	<p>control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on interview the infection control committee failed to monitor the laundering/sanitization of housekeeping microfiber mop heads and cleaning cloths.</p> <p>Findings Include:</p> <p>1. At 9:35 AM on 4/20/16, interview with the director of EVS (environmental services) at the host hospital, staff member #55, confirmed that EVS microfiber mop heads and cleaning cloths go to Cintas for laundering, not to the hospital's contracted laundry service.</p> <p>2. At 10:50 AM on 4/20/16, interview with the DQM (director of quality management)/infection control supervisor, staff member #50, confirmed that:</p> <p>A. It was unknown that the microfiber mop heads and cleaning cloths were laundered in a different contracted facility than what was used for other facility linens.</p> <p>B. The infection control committee was not currently monitoring the Cintas laundering process for EVS supplies.</p>	S 0612	<p>The Infection Control Committee failed to monitor thelaundrying/sanitization of housekeeping microfiber mop heads and cleaningcloths.</p> <p>The Respiratory Therapy Supervisor contacted the hosthospital's Environmental Services Manager to obtain a copy of the host's inspectionof Laundry/sanitation services for mop heads and cleaning cloths. This wasreceived on 6/3/16.</p> <p>The Director of Quality Management will add laundry/sanitationservices of the host for mop heads and cleaning cloths to the quarterlycontract matrix report.</p> <p>To ensure ongoing compliance, the laundry/sanitationservices of the host will be reviewed on a quarterly basis and compliance willbe reported in the quarterly Organizational Improvement Committee meeting. The inspectionreport from laundry/sanitation services will be reviewed during an ad hoc OrganizationalImprovement Committee and Governing Board meeting that will take place on orbefore 6/27/16.</p> <p>This corrective action will be completed by 6/27/16.</p>	06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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S 0672 Bldg. 00	<p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(e)</p> <p>(e) All nursing and other hospital personnel performing out-of-laboratory testing shall have annually updated performance certification maintained in the employee file for the procedures being performed.</p> <p>Based on document review and interview, the facility failed to ensure the skills competency for 1 of 2 RNs (registered nurses) hired in 2015, RN P3, in relation to point of care testing, specifically glucometer testing, and blood administration.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of the document "Mandatory Training 2015", indicated on page one that RNs were to have competency in 8.f. "Medication & Blood Administration", and on page two in item #2, "Glucose POC (point of care) Competency". Review of RN personnel files indicated that RN P3 was hired 2/18/15 and had no documentation in the file for 2015 mandatory training for POC competency and blood administration competency. At 12:34 PM on 4/20/16, interview 	S 0672	<p>During the survey, it was identified that the facility failed to ensure the skills competency for 1 of 2 RNs hired in 2015 in relation to point of care testing, specifically glucometer testing, and blood administration was completed and documented in the employee's file.</p> <p>The Chief Nurse Officer will complete a point of care testing and blood administration competency for the RN identified and place in the employee's file as of 6/8/16.</p> <p>The Chief Nurse Officer will conduct an audit of the education records of the other RN staff to ensure point of care testing and blood administration competencies are complete. The Chief Nurse Officer will complete competencies with any other RNs missing check-offs.</p> <p>To ensure ongoing compliance for new RN hires, the Human Resources Coordinator will send the Chief Nurse Officer a 30, 60, and 90 day employee evaluation reminder so that the Chief Nurse Officer can review with the employee any</p>	06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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S 0952 Bldg. 00	<p>with staff member #52, human resources, confirmed that no documentation could be found for RN P3 either at the time of hire, or later in 2015, related to the 2015 mandatory training for POC competency and blood administration competency.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on document review, observation and interview, the facility failed to ensure that blood transfusions were administered according to facility policy/procedure for 1 of 3 transfusion patients (PT #2).</p> <p>Findings Include:</p> <p>1. Review of policy/ procedure</p>	S 0952	<p>outstanding competencies that need completed and devise a planfor completing them during their first 90 days of employment. Competencies willbe conducted annually for all RNs as a part mandatory training. Compliance with90 day and annual competencies will be reported in the quarterly GoverningBoard meeting. Any RNs who have not completed required competencies will not beallowed to work until they are completed. This corrective action plan will be completed by 6/27/16.</p> <p>During the survey, it was identified that the facilityfailed to ensure that blood transfusions were administered according to thefacility's policy and procedure. Issues identified include: blood products nothing within 30 minutes of receipt from the Blood Bank; more than one unit ofblood being released per patient at one time; blood that was unable to be</p>	06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2016	
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	<p>CLINICAL SERVICES POLICY AND PROCEDURE, B04-N, BLOOD/BLOOD COMPONENTS ADMINISTRATION (PACKED CELLS, PLASMA, PLATELETS, CRYOPRECIPITATE) on page 2 indicated the following;</p> <p>11. Only a RN (registered nurse) or physician can hang blood. Ideally blood is to be started within 30 minutes of receipt from Blood Bank. Under no circumstances is blood to be stored in refrigerator on the nursing units. Only one unit of blood is released per patient at one time. If unable to give within 30 minutes, return blood to Blood Bank with transfusion form. This policy/ procedure was last reviewed/ revised on 7-1-12.</p> <p>2. Review of patient blood transfusion records indicated that on 4-12-16 at 1555 hours there were 2 units of blood signed out to the unit at the same time for PT #2. The record also indicated that the transfusion of unit 2 started at 1630 hours.</p> <p>3. Review of patient blood transfusion records indicated that on 4-16-16 at 1520 hours Blood Bank time that 2 units of blood were signed out to the unit for PT #2. The document indicated a lack of a date and time from the receiving unit.</p>		<p>given with 30 minutes not being returned to the Blood Bank with the transfusion form; and missing documentation of date and time the receiving unit was picked up from the Blood Bank. The Director of Quality Management and Chief Nurse Officer was responsible for re-educating the RN's on the facility's Clinical Services Policy and Procedure, B04-N Blood/Blood Components Administration policy regarding: only picking up one unit per patient at one time, hanging the unit within 30 minutes of receipt from the Blood Bank, a returning the unit to the Blood Bank with the transfusion form if it is unable to be hung within 30 minutes from receipt, and documenting date and time received from the Blood Bank. To ensure ongoing compliance, the Director of Quality Management will also be responsible for auditing all blood/blood product transfusions monthly until compliance achieved to ensure the policy is being followed. Results of these audits will be reported in the monthly QAPI meeting and as well as in the quarterly Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings. These results will be reviewed in an ad hoc Organizational Improvement Committee and Governing Board meeting that will take place on or before 6/27/16. This corrective plan will be</p>				

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S 1118 Bldg. 00	<p>Unit 1 was indicated to have been started at 1615 hours and unit 2 was started at 1645 hours.</p> <p>4. On 4-19-16 at 1425 hours staff #50 confirmed the findings in item 2 and 3 above.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation and interview the facility failed to maintain an environment free from hazards to patients, public or employees related to 1 of 1 lab refrigerators.</p> <p>Findings include:</p> <p>1. While on tour on 4-19-16 at 0959 hours with staff #52 it was observed in the 7th floor soiled utility room that the lab refrigerator had a Nourishment Room Refrigerator/Freezer Temperature log</p>	S 1118	<p>completed as of 6/27/16.</p> <p>Based on a document review, it was identified that the facility failed to maintain an environment free from hazards to patients, public, or employees related to 1 of 1 lab refrigerator.</p> <p>The Director of Pharmacy initiated a specific lab refrigerator log with an updated acceptable temp range included. This was completed as of 4/30/16, and the facility started using the new log as of 5/1/16.</p> <p>The Director of Quality Management was responsible for providing staff education regarding the new log</p>	05/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2016	
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S 1162 Bldg. 00	<p>dated for April 2016 on it. The log form was lacking documentation of having a daily check completed for 9 days.</p> <p>2. On 4-19-16 at 0959 hours staff #52 confirmed the finding.</p> <p>3. On 4-20-16 at 0930 hours staff #50 confirmed that the facility did not have a specific lab refrigerator temperature log or policy relating to a lab refrigerator.</p> <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: (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</p>			S 1162	<p>and ensuring that the lab refrigerator temperature is being checked and documented daily. This was completed on 5/5/16.</p> <p>To ensure ongoing compliance, the lab refrigerator was added to the monthly Environment of Care and Infection Control Rounds to ensure the temps are checked and documented daily. Compliance will be reported in monthly the QAPI meetings and quarterly in the Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings.</p> <p>This corrective action was completed as of 5/5/16.</p>		06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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S 1164 Bldg. 00	<p>interview, the facility failed to document a schedule for preventive maintenance (PM) of 3 of 9 pieces of equipment in accordance with the manufacturer's recommended maintenance schedule.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 04-18-2016 at 11:15 am, employee #A1, Director Quality Management, was requested to provide documentation of a schedule for preventive maintenance (PM) of a C-arm/portable x-ray machine, renal dialysis machine, and bladder scanner, in accordance with the manufacturer's recommended maintenance schedule. 2. No documentation for the above equipment was provided. 3. Interview of employee #A1, Director Quality Management, on 04-20-2016 at 12:50 pm, confirmed the above and no documentation was provided prior to exit. <p>(d) The equipment requirements are as follows:</p>		<p>schedule for PM of 3 of 9pieces of equipment in accordance with the manufacturer's recommendedmaintenance schedule.</p> <p>The Respiratory Therapy Supervisor/Safety Officer obtainedthe records of PMs for the C-arm/portable x-ray machines, renal dialysismachines, and the bladder scanner used in the facility through contractedservices. All of these PMS for the c-arm/portable x-ray machines, renal dialysismachines and bladder scanner were compliant in accordance with manufacturerrecommendations.</p> <p>The Materials Manger will ensure all medical equipment has ashad required PM checks and compliance is documented. This includes for theC-arm/portable x-ray machines, renal dialysis machines, and bladder scanner.</p> <p>The compliance of PM checks will be reported quarterly inthe Organizational Improvement Committee, Medical Executive Committee, andGoverning Board meetings.</p> <p>This action plan will be completed by 6/27/16.</p>	

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	<p>(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 evidence of preventive maintenance (PM) for 6 of 11 pieces of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 04-18-2016, at 11:15 am, employee #A1, Director Quality Management, was requested to provide documentation of PM on a C-arm/portable x-ray, EKG (electrocardiograph) machine, renal dialysis machine, and a bladder scanner. On 04-19-2016 at 2:30 pm, facility staff was requested to provide documentation of PM of 2 Braun medication pumps, facility asset tag numbers 61413 and 70907, located in a storage room on the 8th floor. No documentation of evidence of PM for the above-stated 4 pieces of equipment was provided. Interview of employee #1A, Director 	S 1164	<p>The hospital failed to provide evidence of preventivemaintenance for 6 of 11 pieces of equipment. The Respiratory Therapy Supervisor/Safety Officer obtainedthe records of PMs for the C-arm/portable x-ray machines, renal dialysismachines, and the bladder scanner used in the facility through contracted services. All of the PM reports for the c-arm/portable x-ray machines, renaldialysis machines and bladder scanner were received and compliant in accordancewith manufacturer recommendations.</p> <p>During the survey when it was identified that the 2 Braun medicationpumps were missing PM stickers, they were immediately pulled from service bythe Materials Manager. The preventative maintenance checks on the Braunmedication pumps were completed on 4/20/16. The Materials Manager (with the cooperation of theSafety Officer, Director of Quality Management, and contracted companies) willmaintain an updated copy of the preventative</p>	06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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S 1166 Bldg. 00	<p>of Quality Management, confirmed all the above and no documentation as provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</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>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks. Based on document review and interview, the hospital failed to document a current leakage check on 4 of 9 pieces of equipment.</p> <p>Findings include:</p> <p>1. On 04-18-2016 at 11:15 am, employee #A1, Director Quality Management, was requested to provide documentation of</p>	S 1166	<p>maintenance reports to ensure all medical equipment obtains a preventative maintenance check as scheduled and compliance will be reviewed in the quarterly Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings.</p> <p>This action plan will be completed by 6/27/16.</p> <p>The hospital failed to document a current leakage check on 4 of 9 pieces of equipment. The Respiratory Therapy Supervisor obtained current documentation for the required current leakage checks of the c-arm/portable x-ray machines, renal dialysis machines, bladder scanner, and EKG equipment utilized in the facility. The reports regarding these checks were all received as of 6/6/16.</p>	06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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S 1168 Bldg. 00	<p>current electrical leakage checks for 9 pieces of equipment.</p> <p>2. Review of documents indicated there was no documentation of current electrical leakage check for a C-arm/portable x-ray, EKG (electrocardiograph) machine, renal dialysis machine, and a bladder scanner.</p> <p>3. Interview of employee #A1, on 04-20-2016 at 12:50 pm, confirmed there was no above-requested documentation. No other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the facility failed to follow the manufacturer's recommendation for daily testing of 2 of 2 defibrillators, 15% of the time, and failed to perform, at each shift, 5 of 6 checks.</p>	S 1168	<p>The Materials Manager (with the cooperation of the Safety Officer, Director of Quality Management, and contracted companies) will maintain an updated copy of the current leakage reports to ensure all are completed as scheduled and compliance will be reviewed in the quarterly Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings.</p> <p>This corrective action will be completed by 6/27/16.</p> <p>It was identified during the survey that the facility failed to follow the manufacturer's recommendation for daily testing of 2 of 2 defibrillators 15% of the time and failed to perform at each shift 5/6 checklists. The Chief Nurse Officer re-educated the charge nurses on completing the</p>	06/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152016	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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	<p>Findings:</p> <p>1. Review of the manufacturer's manual for the facility's Zoll defibrillator indicated "Recommended checks and procedures to be performed at the start of each shift."</p> <p>2. Review of documents entitled Emergency Equipment/Code Cart Check List, dated February, 2016, indicated the following checks were not conducted:</p> <table border="1"> <thead> <tr> <th>7th Floor</th> <th>Date</th> <th>Shift</th> <th>8th Floor</th> </tr> </thead> <tbody> <tr> <td></td> <td>Date</td> <td>Shift</td> <td></td> </tr> <tr> <td></td> <td>2-2</td> <td>1</td> <td>2-2 2</td> </tr> <tr> <td></td> <td>2-8</td> <td>1</td> <td>2-9 1</td> </tr> <tr> <td></td> <td>2-9</td> <td>1</td> <td>2-10 2</td> </tr> <tr> <td></td> <td>2-10</td> <td>1, 2</td> <td>2-11</td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>2-14</td> <td>2</td> <td>2-15 1</td> </tr> <tr> <td></td> <td>2-16</td> <td>1</td> <td>2-19 2</td> </tr> <tr> <td></td> <td>2-18</td> <td>1</td> <td>2-21 1</td> </tr> <tr> <td></td> <td>2-19</td> <td>2</td> <td></td> </tr> <tr> <td></td> <td>2-24</td> <td>2</td> <td></td> </tr> </tbody> </table> <p>3. Review of the manufacturer's manual document entitled Operator's Shift Checklist for ZOLL 1600 Semi-Automatic Mode & ZOLL 1600 Manual Mode, indicated the "Recommended checks and procedures to be performed at the start of each shift" include:</p>	7th Floor	Date	Shift	8th Floor		Date	Shift			2-2	1	2-2 2		2-8	1	2-9 1		2-9	1	2-10 2		2-10	1, 2	2-11	2					2-14	2	2-15 1		2-16	1	2-19 2		2-18	1	2-21 1		2-19	2			2-24	2			<p>defibrillator daily testing per the manufacturer's recommendations. The manufacturer's checklist is being used to document the daily checks. To ensure compliance the Chief Nurse Officer or designee will audit the defibrillator testing checklists weekly to ensure that it is being completed per the manufacturer recommendations until compliance is achieved. This corrective action was completed as of 6/1/16.</p>	
7th Floor	Date	Shift	8th Floor																																																	
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	2-2	1	2-2 2																																																	
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NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY 7TH FL E FORT WAYNE, IN 46802
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	<p>1. ZOLL 1600 Condition Unit clean, no spills, clear of objects on top, case intact</p> <p>2. Defibrillator Pads Package sealed, with appropriate expiration date</p> <p>3. Inspect cables for cracks, broken wires, connectors B. Multi-function cable, connector</p> <p>4. Batteries (2) A. Fully charged battery in unit B. Fully charged spare battery available</p> <p>5. Memory Cards (2)</p> <p>6. Disposable Supplies C. Alcohol wipes D. Razors E. Antiperspirant</p> <p>4. Review of documents entitled Emergency Equipment/Code Cart Check List, dated February, 2016, for the 7th and 8th floors, indicated the above-stated checks were not performed.</p> <p>5. Interview of employee #A1, Director Quality Management, on 04-19-2016 at 10:05 am, confirmed all the above and no</p>			
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S 1172 Bldg. 00	<p>other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation and interview, the facility failed to ensure that nursing and RT (respiratory therapy) staff maintained</p>	S 1172	Based on observation and interview, it was determined that the facility failed to ensure that nursing and RT	06/27/2016

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	<p>a clean environment in relation to the cleanliness of their VS (vital signs) monitors, their WOWs (workstation on wheels), and the code carts.</p> <p>Findings Include:</p> <p>1. On 4/19/16, while on tour of the 7th floor nursing unit in the company of staff member #53, the charge nurse, it was observed that:</p> <p>A. At 9:55 AM, the Dynamap mobile VS cart had an accumulation of dust and debris on the base of the unit.</p> <p>B. At 10:30 AM, the code cart had an accumulation of dust on the top, especially at the back behind the defibrillator/monitor.</p> <p>C. At 10:35 AM in the hallway outside room 701, the RT cart (Rubbermaid server)/WOW had an accumulation of dust present on the base of the unit.</p> <p>D. At 10:40 AM it was observed that the Rubbermaid server across from the Materials Management room had an accumulation of dust on the base of the unit.</p> <p>E. At 10:50 AM, in the nursing station, a Rubbermaid server was observed with an accumulation of dust on the base of the unit.</p> <p>2. At 10:55 AM on 4/19/16, interview with staff member #53 confirmed the WOWs and code cart on the 7th floor had</p>		<p>staff maintained a clean environment in relation to the cleanliness of the vital signs (VS) monitors, workstations on wheels (WOWs), and code carts.</p> <p>All above identified equipment has been cleaned. The Director of Quality Management will re-educate the nursing and respiratory staff to clean the VS monitors daily, the WOWs every shift, and code carts daily or when visibly soiled.</p> <p>The Director of Quality Management will audit the VS monitors, WOWs, and code carts during monthly Infection Control rounds to ensure cleanliness. Compliance will be reported in the monthly QAPI meeting and quarterly in the Organizational Improvement Committee, Medical Executive Committee, and Governing Board meetings.</p> <p>This corrective action plan will be completed as of 6/27/16.</p>	

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S 1186 Bldg. 00	<p>dust/debris on the base of the units as listed in 1. above.</p> <p>3. On 4/19/16 at 2:44 PM, while on tour of the 8th floor nursing unit in the company of staff member #50, the DQM (director of quality management), it was observed that the code cart at the nursing station had dust behind the defibrillator/monitor and on the base of the cart.</p> <p>4. At 9:30 AM on 4/20/16, interview with staff member #50 confirmed that there was dust present the code cart on the 8th floor on 4/19/16 and that the facility had no policy specific to nursing and RT staff responsibilities in cleaning their Rubbermaid servers and the code carts.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</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>(A) Patient safety. (B) Health care worker safety.</p>			

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	<p>(C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following:</p> <ul style="list-style-type: none"> (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. <p>Based on document review and interview, the facility failed 'to include in its fire control plan a provision to cooperate with firefighting authorities in 1 instance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility policy NUMBER: 28, entitled Fire Plan, REVISION DATE: 01/01/16, indicated it did not include a provision to cooperate with firefighting authorities. 2. Interview of employee #A1, Director Quality Management, on 04-19-2016 at 9:55 am, confirmed the above and no other documentation was provided prior to exit. 	S 1186	<p>The facility failed to include in its fire control plan a provision to cooperate with firefighting authorities in 1 instance.</p> <p>The Fire Response Plan was revised as of 6/6/16 to include a provision that staff would cooperate with fire-fighting authorities and follow their instructions until termination of the code red.</p> <p>The Respiratory Therapy Supervisor/Safety Officer and Director of Quality Management has been educating staff of this new provision. All staff will be educated by 6/27/16.</p> <p>This corrective action plan will be completed by 6/27/16.</p>	06/27/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/28/2016
FORM APPROVED
OMB NO. 0938-0391

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