

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/30/2013	
NAME OF PROVIDER OR SUPPLIER  HENDRICKS REGIONAL HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 E MAIN ST DANVILLE, IN 46122			
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005005</p> <p>Survey Date: 10/28-30/13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 11/13/13</p>			S000000	Hendricks Regional Health acknowledges the survey team and findings.		

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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S000270	<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 the 2 services, Animal Therapy and contracted Pharmacy.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the Animal Therapy and contracted Pharmacy services.</li> <li>In interview, on 10-30-12 at 3:30 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S000270	<p>Animal Therapy Immediate Response: On 11/21/2013, QRM staff reached out to Guest and Support Services to seek an evaluation of the Paws to Pet Program. After discussions with Guest and Support Services Directors, there are intricate records kept for both the animal's handlers as well as health records on the dogs themselves. However, these items were not available at time of ISDH survey. To facilitate review of Pet Therapy, a 2012 Contract Review form (File: 2012 Annual Contract Form - ANIMAL THERAPY) was filed to QRM 11/21/13. Status: Completed 11/21/2013</p> <p>Responsibility for Plan of Correction: Moving forward, the Guest and Volunteer Services Director will include metrics regarding performance of Animal Therapy Program in its</p>	11/21/2013			

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			<p>Department Quality Assurance Reports, due every November to Quality Steering Committee. This evaluation will be included in the November Quality Steering Committee Minutes which is shared with Medical Executive Committee and the Board of Directors. Staff Member Responsible: Director, Guest and Volunteer Services PHARMACY SERVICES Immediate Response: HRH currently contracts with Pharmacy Systems, Inc. for management personnel of the pharmacy activities at HRH. The only contracted employee is Mark Roy, Director of Pharmacy. All other pharmacy employees are directly employed by Hendricks Regional Health. As identified during the ISDH visit, evaluations of Pharmacy Systems, INC. were covered as part of the annual personnel review of Mark Roy by HRH VPMA. To supplement contracted services review requirements, on 11/21/2013, a 2012 Contract Evaluation Form (File: 2012 Annual Contract Review - PHARMACY SYSTEMS, INC) was completed for Pharmacy Systems, INC. Status: Completed 11/21/2013 Responsibility for Plan of Correction: To ensure that Pharmacy Systems, INC. continues to be evaluated, a contract evaluation form will be completed by the Vice President of Medical Affairs on an annual</p>	

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S000406	<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 1 service provided by the hospital as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI</p>	S000406	<p>basis, evaluated by the Quality Steering Committee in December of each year moving forward. This evaluation will be included in the December Quality Steering Committee Minutes which is shared with Medical Executive Committee and the Board of Directors. Staff Member Responsible: Vice President of Medical Affairs.</p> <p>Animal Therapy Immediate Response: On 11/21/2013, QRM staff reached out to Guest and Support Services to seek an evaluation of the Paws to Pet Program. After discussions with Guest and Support Services Directors, there are intricate records kept for both the animal's handlers as well as health records on the dogs themselves. However, these items were not available at time of ISDH survey. To facilitate review of Pet</p>	11/21/2013	

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S000554	<p>program indicated it did not include monitors and standards for the service Animal Therapy.</p> <p>2. In interview, on 10-30-12 at 3:30 pm, employee #A1 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 interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p> <p>Findings included:</p> <p>1. During the tour of the perioperative area at 2:30 PM on 10/28/13,</p>	S000554	<p>Therapy, a 2012 Contract Review form (File: 2012 Annual Contract Form - ANIMAL THERAPY) was filed to QRM 11/21/13. Status: Completed 11/21/2013Responsibility for Plan of Correction: Moving forward, the Guest and Volunteer Services Director will include metrics regarding performance of Animal Therapy Program in its Department Quality Assurance Reports, due every November to Quality Steering Committee. This evaluation will be included in the November Quality Steering Committee Minutes which is shared with Medical Executive Committee and the Board of Directors.Staff Member Responsible: Director, Guest and Volunteer Services</p> <p>Correction of Deficiency:Perianesthesia associates performed immediate removal of outdated supplies present on the Block Cart with all replacement supplies checked to ensure none outdated for the next 30 days on 10/28/13. Subsequent replacements were monitored by Clinical Manager to ensure none expire prior to 11/26/13 and staff</p>	11/26/2013

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	<p>accompanied by staff members #P3, P8, P12, and P13, an anesthesia block cart was observed in the hallway. The drawers of the cart were checked and the following expired items were found:</p> <p>A. Four of four packages of EKG backpads, two expired 01/2012, one expired 05/2012, and one expired 03/2013.</p> <p>B. Six of fifteen transparent dressings expired 05/2013.</p> <p>C. One of one opened 16-ounce bottle of Betadine with a manufacturer's expiration date of 02/10.</p> <p>D. One of one epidural catheter kit expired 03/2013.</p> <p>E. Four of seven nerve block kits with an expiration date of 01/2013.</p> <p>2. At 2:35 PM on 10/28/13, staff member #P12 indicated their staff routinely checked and replenished the supplies in all of the carts and storage areas. Staff member #P17 indicated he/she performed the general checks of the supplies, including the anesthesia block cart.</p>		<p>education began through staff meetings. Prevention of future deficiency:Initiation of a monthly check list sign-off for the Perianesthesia Block Cart, as is currently done with department code cart (see attached record) 11/26/13. The assigned associate who replaces supplies will check all replacements to verify that none expire within 30 days (cart has rapid turnaround) from the check, sign and date the record. Overlapping separate monthly Block Cart checks will be completed by an assigned associate who will check all expiration dates of supplies on the cart; remove and replace any bearing expiration dates within 30 days, sign and date the record. Block Cart check is reported as a quality indicator quarterly. Responsible party for correction and prevention of deficiency:Clinical Manager of Perianesthesia Services is responsible for monitoring the monthly process and reporting as a quality indicator quarterly with review to staff in postings and staff meetings. Date of correction completion: Initial correction of outdates completed 10/28/13. Plan completion 11/26/13 with full department staff education in their role for checking the Block Cart supply outdates at time of replacement and monthly, as assigned. Please refer to File: S0554 Log Sheets</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 medical record review, policy and procedure review, and interview, the nurse executive failed to ensure assessments were done according to policy and protocol for 4 of 5 pediatric</p>	S000912	Nurse Executive failed to ensure assessments were being done according to policy and protocol: Chart Review (N1,N2,N3,N4 in #1,2,3,4 and 6)) Assessment/reassessment of	11/22/2013

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	<p>patients (#N1, N2, N3, and N4), for 1 of 2 newborns (#N7), and for 2 of 2 patients with restraint use (#N18 and N19).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The medical record for patient #N1, a 9-month old who was seen in the Emergency Department (ED) and admitted to the facility on 03/09/13, lacked documentation of a pain assessment in the ED. The record also lacked documentation of a head circumference measurement with the admission assessment to the pediatric unit.</li> <li>2. The medical record for patient #N2, a 19-month old who was seen in the ED and admitted to the facility on 04/06/13, lacked documentation of a pain assessment in the ED.</li> <li>3. The medical record for patient #N3, a 1-month 17 day old who was seen in the ED and admitted to the facility on 06/20/13, indicated ED pain documentation, "no apparent source of pain- cries age appropriate and is easily consolable w/holding/rocking. Patient is unable to relate pain to scale." The record lacked documentation of a head circumference measurement with the</li> </ol>		<p>pediatric patient for pain in the Emergency Department (ED) Correction: Emergency Department staff education completed 11/1/13 on assessment and reassessment policy which included specific language addressing the pediatric population. The ED electronic health record was changed on 11/1/13 by rearranging where pain scales are located in the record. Pain assessment scales for patients are now located next to the assessment documentation section. November 18, 19, and 20th, department staff meetings held with discussion on assessment policies, triage policy and documentation. Prevention of Future Deficiency: An audit tool was developed that assesses the pediatric population needs. The tool includes assessment upon arrival and use of appropriate pain scales (Wong or Faces) based on age, pain reassessment prior to discharge, pain reassessment after an intervention, heart rate by apical count for newborn -2 years of age, immunization status assessed, if not current, recorded last immunization received and date. A minimum of 30 charts will be audited monthly with feedback to staff by the Director and Clinical Manager through department postings and staff meetings. Responsible party for correction and prevention of deficiency Director Emergency</p>		

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	<p>admission assessment to the pediatric unit.</p> <p>4. The medical record for patient #N4, a 17-month old who was seen in the ED and admitted to the facility on 07/25/13, lacked documentation of a pain assessment in the ED. The infant was brought by ambulance service to the ED at 10 :45 AM due to febrile seizures and the initial temperature was 103.9 degrees Fahrenheit with no axillary or rectally route designated. The infant was designated as a Class 2 Emergent visit and was seen immediately with treatment started. Documentation indicated an Acetaminophen Suppository was given at 11:05 AM, bolus intravenous fluids were given at 11:10 AM, and Ibuprofen Suspension was given at 11:37 AM. The record lacked any documentation of the temperature being rechecked prior to the infant going to the pediatric unit at 1304 although other vital signs were rechecked at 11:21 AM and 11:46 AM.</p> <p>5. The medical record for patient #N7, an infant born at 1815 on 06/06/13, indicated documentation of a circumcision performed at 2000 on 06/07/13, but lacked any documentation of care or condition of the site until midnight on 06/08/13.</p>		<p>Department is responsible for monitoring the monthly process and reporting as a quality indicator quarterly.Plan Completion: November 20, 2013. (N4 in #4 and 7) Triage of Emergency Department Patients-reassessment of temperature Triage class 2 Emergent: patient (febrile)Correction: Deficiency correction began 11/01/13 with direct education of staff involved. Review of the triage policy at departmental November 18, 19, and 20th staff meetings. Prevention of Future Deficiency: Reassessment of abnormal vital signs with intervention have been added to the monthly audits for ED with feedback to staff by the Director and Clinical Manager through department postings and staff meetings .Responsible party for correction and prevention of deficiency: Director Emergency Department is responsible for monitoring the monthly process and reporting as a quality indicator quarterly.Plan Completion: November 20, 2013 (N1, N3 in #1, 3 and 9) Assessment of occipital frontal circumference (OFC) on pediatric patient less than 1 year of ageCorrection: Deficiency correction began 11/01/13. Education began with staff on policy and need to add the intervention until electronic correction could be made. At the direction of the Clinical Manager</p>		

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	<p>6. The facility policy "Assessment and Reassessment of Patients- ED", last revised 03/12, indicated, "8. Assessment of physical pain will be included in the initial assessment of all patients. ...Wong's preverbal Pain Behavior Scale will be used for children less than 2 years old... Reassessment: ...5. Vital signs will be repeated based on clinical status and interventions (i.e. fluid administration, narcotic/sedative administrations, etc.)."</p> <p>7. The facility policy "Triage of Emergency Department Patients", last revised 05/11, indicated, "III. At triage, an assessment/evaluation is performed by an RN [Registered Nurse]. Based on urgency of the patient needs the RN places the patient into a category. ...B. Class 2 (Emergent)- Immediate needs received definitive are with no brief delay. Reassessment every 15 minutes."</p> <p>8. The facility policy "Pain Management", last reviewed 03/12, indicated, "C. The patient will be screened for pain upon his/her arrival for treatment including, but not limited to, the following: i.e., inpatient care, emergency care, ...using a pain assessment scale."</p>		<p>of Pediatrics, Information Systems department revised the electronic Pediatric Admission Assessment to default the intervention in the standard of care for the age group. Revision was run in test 11/04/13, making the response to head circumference for patients when age checked is less than 1 year a labeled field. Nurses no longer need to add an additional intervention for identified patients. Education for all Pediatric Unit staff was completed in both written and verbal form for revised charting activation 11/18/13. Prevention of Future Deficiency: Monthly audits of all pediatric patient Admission Assessment queries for OCF in those less than one (1) year of age were added for reporting as a quarterly Pediatric Unit Quality Indicator with feedback to staff by the Director and Clinical Manager through department postings and staff meetings. Responsible party for correction and prevention of deficiency: Director Pediatrics Department is responsible for monitoring the monthly process and reporting as a quality indicator quarterly. Plan Completion: November 20, 2013. (N7 in #5 and 10) No reassessment of circumcised patient per policy at 30 and 60 minutes Correction: The associate involved with this patient received a "Just Culture" coaching on 11/1/13 for the lack of</p>				

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	<p>9. The facility policy "Care of the Pediatric Patient", last revised 12/11, indicated, "VIII. Assessments: ...B. Measure height and weight on admission. Measure Occipital Frontal Circumference (OFC) in all patients under the age of 1 year, and as ordered."</p> <p>10. The facility's newborn Circumcision Careplan indicated, "Assess at 30 minutes and again at 60 minutes post procedure for the following: Assess operative site for bleeding; apply pressure if needed, notify provider if necessary; Apply dressing per provider specific preference; Educate mother/SO on S&amp;S of excessive bleeding at circumcision site. Assess operative site for excessive edema or overt signs of infection."</p> <p>11. The medical record for patient #N18, an 85 year old who was hospitalized between 07/08/13 through 07/10/13, indicated physical and chemical restraints beginning at 0900 on 07/09/13, but no physician order until 0600 on 07/10/13. The order was completed by the RN, but lacked documentation of verbal or telephone order and lacked a date and time for the physician's signature. Repositioning of the patient was documented at 1100, 1500, 1945, and 2300 on 07/09/13 and</p>		<p>documentation on this patient per policy. Staff re-education to policy completed in CBC Staff meeting on November 11 and 14, 2013. The system Administrator for the Centricity Perinatal Network (CBC charting system), an RN with OB/Peds experience, currently does monthly audits on completion of circumcision consents. We monitor compliance and coach staff accordingly with reminders given in staff meetings. For the noted area of noncompliance with documentation, the System Administrator will audit a total of 30 charts a month to assure compliance with documentation and assessments of circumcisions. We will include this as one of our Quality Indicators and follow up for noncompliance will be followed by the Nursing Director by use of the "Just Culture" algorithm Prevention of Future Deficiency: The system Administrator for the Centricity Perinatal Network (CBC charting system), an RN with OB/Peds experience, currently does monthly audits on completion of circumcision consents. We monitor compliance and coach staff accordingly with reminders given in staff meetings. For the noted area of noncompliance with documentation, the System Administrator will audit a total of 30 charts a month to assure compliance with documentation and assessments of</p>		

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	<p>not every 2 hours as specified by policy.</p> <p>12. The medical record for patient #N19, a 72 year old who was hospitalized between 07/12/13 through 07/18/13, indicated physical restraints beginning at 2015 on 07/14/13. The order was completed by the RN, but lacked documentation of verbal or telephone order and lacked a date and time for the physician's signature. Reassessment of the patient was documented at 2300 on 07/14/13 and 0156 and 0513 on 07/15/13, not every 2 hours as specified by policy.</p> <p>13. The facility policy "Medical Record Entry Authorization and Authentication", last reviewed 03/13, indicated, "G. Signature authentication of hospital associates requires at least the date and time of entry and a first name, initial, last name, and job designation."</p> <p>14. The facility policy "Verifications of Verbal/Telephone Orders and Critical Values", last reviewed 09/13, indicated, "B. Telephone orders will be accepted only from the responsible practitioner or his designee. C. Verbal and telephone orders are to be repeated and read back by the receiver at the time of the order. ...E. The read back and verification</p>		<p>circumcisions. We will include this as one of our Quality Indicators and the Nursing Director will use the "Just Culture" algorithm to follow up for noncompliance. Responsible party for correction and prevention of deficiency: Director, ChildBirth Center is responsible for monitoring the monthly process and reporting as a quality indicator quarterlyPlan Completion: November 22, 2013. (N18,19 in #13, 14 and 15) Restraint usage not meeting policy with insufficiently signed order and missing monitoring reassessment Correction: First 30 days: Deficiency correction began 11/01/13. Review of additional restraint charts was initiated, finding issue with the paper charting process/format in use. Re-education of staff on ordering and q2hour monitoring policy added to staff meetings with survey response update added to Nursing Collaborative Council meeting 11/21/13. Revised paper Restraint Order format as a transition document to electronic charting was completed 11/21/13 with staff education on use and 2 hour checks with activation 11/25/13. The new form contains the same information as the "label" use in verbal orders or captured in electronic ordering. If verbal order, the physician e-signs (electronic notification goes to him/her at order entry to sign his verbal/telephone order.)Information Systems</p>				

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	<p>label is to be used when the order is written in the medical record documenting the physician name, time, date, and signature of the receiver."</p> <p>15. The facility policy "Restraint and/or Seclusion, Use of", last reviewed 12/12, indicated, "II. Orders: The use of each restraint or seclusion episode must be in accordance with the order of a physician who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with Indiana law. Order for the use of restraint or seclusion must never be written as a standing order or as an as-needed basis (PRN). The physician order for restraint or seclusion must include: Date and time of order, Justification/rationale for use, Type of restraint, Time-limited duration (not to exceed 24 hours). A. The order must be obtained either during the emergency application of the restraint or immediately after the restraint has been applied. If the attending physician does not order the restraint or seclusion, the attending physician must be consulted as soon as possible. This requirement may be achieved through a telephone call. ...IV. ...A. Reassessment of the non-violent, non self destructive patient will be done at a minimum every two hours ...Nursing care will include</p>		<p>identified a reasonable transition to electronic format for implementation would be in second 30 day section of plan. Task Force Members were identified for full restraint process review and electronic conversion of record as an update to the correction. Staff education began immediately on monitoring parameters (2 hour) with reminder to Collaborative Council for education, already in monthly audits for restraints, reported quarterly and follow-up by Director with staff. Days 31-60: Restraint Task Force will do full policy review, set parameters for electronic ordering, quality audit content review, and review/revise documentation with IS, targeting a policy revision and plan for activation of an update to an electronic system for ordering/documentation for Restraints by 12/26/13. Prevention of Future Deficiency: All revised interim paper Restraint Orders will be audited manually for use in staff education and team revision from 11/26/13 until the activation of 12/26/13 plan, when orders will be added to the electronic audit and submitted in QI reporting quarterly with feedback to staff by the department directors and clinical managers through department postings and staff meetings. Directors currently monitor restraint documentation and monitoring (2 hour checks) through electronic audits monthly</p>				

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	<p>change of body position (turning, propping, etc.), release/rotation and limb range of motion every two hours."</p> <p>16. At 9:40 AM on 10/30/13, staff members #P3 and P10 confirmed the medical record findings for the pediatric patients seen in the ED.</p> <p>17. At 10:00 AM on 10/30/13, staff members #P26 and P27 confirmed the medical record findings for the newborn patient.</p> <p>18. At 2:45 PM on 10/30/13, staff members #P3, P31, and P32 confirmed the medical record findings for the patients with restraint use.</p>		<p>for quarterly QI reporting and Director follow-up. Responsible party for correction and prevention of deficiency: Director Medical and Surgical Nursing is responsible for chairing the Restraint Committee, monitoring the monthly process and ensuring reporting by units using restraints as a quality indicator quarterly (paper and then electronic.) Plan Completion: November 20, 2013(initial correction) and 12/26/13 (electronic transition plan to improve the initial correction.) Responsible party for correction and prevention of deficiency S0912: Director identified in each section of the response is responsible for the chart deficiency correction in her area. Yvonne Culpepper, Vice-president of Nursing is responsible for oversight of the completion of departmental Plans of Correction and assuring reporting through quality indicators quarterly. Date of correction completion for S0912: All elements of the deficiency, S0912 are corrected by 11/26/13. (See each individually for specific completion date.----- ----- Note: e) has a further transition plan extending to 12/26/13 to plan improvement on the correction with an electronic solution.) Please refer to file "S0912 Exhibits" for OFC Charting Screen Shot corresponding to c) Restraint Order form corresponding to e)</p>		

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S000952	<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 transfusion record review, approved medical staff policies and procedures review, and staff interview, the facility failed to follow approved medical staff policies and procedures for seven of seven transfusions reviewed.</p> <p>Findings include: 1. Review of seven transfusion records on 10/29/13 indicated the following times:  <table border="1"> <thead> <tr> <th>Transfusion #</th> <th>Previtals</th> <th>Transfusion</th> <th>Performed</th> <th>Start</th> </tr> </thead> <tbody> <tr> <td>T#1</td> <td></td> <td></td> <td>13:25</td> <td></td> </tr> <tr> <td>T#2</td> <td></td> <td></td> <td>12:37</td> <td></td> </tr> <tr> <td>T#3</td> <td></td> <td></td> <td>10:29</td> <td></td> </tr> <tr> <td>T#4</td> <td></td> <td></td> <td>13:41</td> <td></td> </tr> </tbody> </table> </p>			Transfusion #	Previtals	Transfusion	Performed	Start	T#1			13:25		T#2			12:37		T#3			10:29		T#4			13:41		S000952	<p>Failure to follow policy for pre-transfusion vital signs Correction: In the hospital's transition to electronic charting (still in process), HRH adopted the Meditech Transfusion Administration Record. When vital signs are taken within 15 minutes prior to starting a transfusion per policy, the Meditech functionality does not provide a separate blank for actual time taken, but is designed to have vitals and transfusion documentation start with the hanging of the blood, using this time to trigger the reminder for the next set of 15 minute vitals. (We understand this causes potential of interpreting that first vitals and blood hanging were done simultaneously.) In order to remove this deficiency, Information Systems contacted Meditech and were told that a recent upgrade now allows us to add an additional query for actual time taken in addition to the TAR</p>		11/26/2013
Transfusion #	Previtals	Transfusion	Performed	Start																												
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	<p>T#5 12:03</p> <p>T#6 05:57</p> <p>T#7 16:30</p> <p>2. Review of a policy/procedure titled: "HENDRICKS REGIONAL HEALTH NURSING DEPARTMENT, BLOOD/BLOOD PRODUCTS ADMINISTRATION, PROCEDURE, B. 1. Vital signs will be assessed within 15 minutes prior to administering the blood/blood product to establish a baseline by an RN only."</p> <p>3. In interview on 10/29/13 between 11:00 a.m. and 1:30 p.m., during transfusion record reviews, staff persons #33 &amp; #34 acknowledged, " it appears the Previtals and Start Times are the same." Staff person #34 also indicated " the previtals were done before, but problems with the electronic record did not allow an earlier entry."</p>		<p>without eliminating our ability to track. Actual time taken field will be entered to a query when charting is entered at hanging of the blood allowing us to maintain an auditable, consistent record of the process. Staff education starts 11/21/13 with Collaborative Council, who will complete staff education. New electronic charting field goes active to correct the identified deficiency on 11/26/13. Screen shot of charting attached. Prevention of future deficiency:Department Directors are responsible for follow up on Blood Bank monthly transfusion process audits containing pre-transfusion vital reporting vital signs as a quality indicator quarterly with feedback to staff in meetings and postings. Blood Bank monthly audits are also reported to the multidisciplinary Transfusion Committee for integration into policy review edits, electronic process changes, and future education. Responsible party for correction and prevention of deficiency:Clinical Manager IV Therapy, who is Chairperson of Transfusion Committee, is responsible for reporting thru Director, IV Therapy to the Vice-president of Nursing. Date of correction completion: Pre-transfusion vital signs deficiency corrected 11/26/13.----- Please refer to file "Citation Response addition to 0952" for evidence of documentation</p>		

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S001014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on document review, observation and interview, the facility failed to follow its policy to properly account for the use of drugs and failed to follow its pharmacy policy regarding multidose medications.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled SAMPLES, reviewed 10/2010, indicated a perpetual inventory system shall be used to account for samples. Each time a sample is distributed or removed from stock, the log shall have the quantity for the specific sample reduced by the amount used or removed. Any discrepancies identified regarding remaining quantities of samples must be documented with a record of the investigation effort performed to correct the discrepancy.</p>	S001014	<p>screen.</p> <p>S1014 Pharmacy Policy regarding dating multidose medication administration in the emergency department. Correction of Deficiency: Emergency Department (#5, #6,#7)Multidose Medication Usage and Policy – vials that were open in the medication refrigerator and without a date were discarded. New vials are labeled and dated at this time.Pharmacy clarified on 11/1/13 they will apply labels to each multidose container. Prevention of future deficiency:ED will check daily that multidose containers (insulin) have a Do Not Use After label on the container. The associate opening the vial will date the label stating expire on: 28 days or 4 weeks from the date opened. Education regarding dating of multidose vials provided on 11/1/13 and discussed at departmental staff meetings on November 18, 19, and 20th. Responsible party for correction</p>	11/18/2013			

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	<p>2. On 10-30-13 at 9:50 am in the presence of employees #A1, #A4 and #A7 in the Radiation Therapy area of the Avon Medical Building offsite, it was observed there were 2 bottles of Gel X medication in a secure cabinet.</p> <p>3. Review of a document entitled SAMPLE MEDICATION LOG, indicated there were 4 bottles of the medication placed in the cabinet on 6-14-13. There was no documentation of the quantity for the specific sample used or removed. For the remaining quantities, there was also no documentation of an investigation effort performed to correct the discrepancy.</p> <p>4. At the above date and time, in interview, hospital staff indicated a physician might have given out the other 2 unaccounted for samples. No further documentation was provided prior to exit.</p>		<p>and prevention of deficiency: Emergency Department Director is responsible for monitoring the process monthly and reporting as a quality indicator quarterly. Date of correction completion: Multidose container deficiency corrected 11/1/13. S1014 Pharmacy Policy regarding dating multidose medication administration in the Cancer Center. On October 30, 2013 during audit of medication room it was found that 2 samples of gelX were not signed out or accounted for per Sample Medication Policy. The two nurses employed on the unit are the only two persons in the Cancer Center with keys to the medication cabinet. On lengthy chart review of patients under treatment after the 6/14/13 date that the sample was signed in two samples were identified as given in charting on a patient from 10/18/13. Charting revealed samples were given by physician. (see accompanying chart note) Intentionally, only the nurses have keys to the medication room to ensure samples are recorded. Clearly this nurse was aware of the samples being given and failed to record them. Correctional Action: Effective 11/18/2013, the nurses have added to the Cancer Center Medication Expiration Record that not only expiration be checked but that sample inventory is checked also . (see</p>		

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	<p>5. During the tour of the Emergency Department (ED) at 1:25 PM on 10/28/13, accompanied by staff members #P3, P8, P10, and P11, 3 of 3 open vials of insulin were observed in the medication refrigerator. Two of the vials lacked an opened or expiration date, and the third vial had "opened 10/8/13" handwritten on it.</p> <p>6. At 1:30 PM on 10/28/13, staff member #P10 indicated a 30 day expiration date should be written on the vials after opening.</p> <p>7. The facility policy "Medication Use Process", last reviewed 08/13, indicated, "E. Dating Multidose Containers: 1. The beyond use date for multidose containers after initially entering or opening (needle puncture) is 28 days unless the manufacturer date is less than that time. 2. Pharmacy will attach 'Do Not Use After' labels to multidose containers prior to stocking in Omnicell or dispensing to the units. When</p>		<p>accompanying Medication expiration record) Additionally, education of Cancer Center Nurses on additional procedure was completed 11/18/2013. Director of Cancer Center will be responsible for monitoring expiration records on a quarterly basis. Please see file: S1014 TAR Screenshots.</p>		

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S001028	<p>multidose containers do not have a label, a label will be obtained from unit stock and affixed to the vial. ...The associate opening the multidose container will date the label 28 days, or 4 weeks from the date opened."</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on observation, inter and document review, the hospital failed to follow its policy by allowing access to a medication storage area by an unauthorized person.</p> <p>Findings:</p> <p>1. On 10-28-13 at 3:40 pm, in the presence of employees #A1, #A4 and #A7, it was observed in the Sleep Study control room that there was a locked refrigerator. At that time, a Sleep Study</p>	S001028	After review of ISDH findings, on 11/18/2013, the refrigerator and medications in question were removed from the Sleep Study Lab. On 11/18/2013, the Lab Director, working with Pharmacy Director, developed a new process to ensure availability of meds to Sleep Study Lab should they be needed. Effective 11/18/2013, medications will be provided only by and directly by Pharmacy staff. Education to Sleep Study Lab staff and Pharmacy Staff occurred 11/18/2013.	11/18/2013

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	<p>staff person indicated the refrigerator contained medication and the hospital staff member opened the refrigerator. The refrigerator contained medication.</p> <p>2. In interview on the above date and time, the hospital staff person indicated he/she was a registered EEG (electroencephalography) tech.</p> <p>3. Review of a hospital policy entitled SECURITY OF MEDICATION STORAGE AREA, reviewed 10/2010, indicated all medication storage areas will be either locked or otherwise secured in such a way to prevent access to medications by unauthorized persons. It further indicated service personnel either from within or outside the hospital shall not have access to medication storage areas unless accompanied by a pharmacy associate to handle the medications at all times.</p> <p>4. In interview, on 10-30-13 at 2:45 pm, hospital staff was requested to provide documentation that the Sleep Study EEG tech was approved to access medication. No further documentation was provided by exit.</p>				

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S001186	<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. (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: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy.</p> <p>Findings:</p> <p>1. Review of a document entitled FIRE EMERGENCY PLAN - CODE RED, indicated fire drills are to be held at least quarterly on each working shift.</p> <p>2. Review of fire drills conducted at the</p>	S001186	<p>Immediate Response: Fire drills will be conducted at the Avon Medical Building and HRH YMCA facility before December 31, 2013. Plan of Correction for future:A review of HRH's Fire Emergency Plan-Code Red policy and fire drills will be performed with conclusions reported to the Safety Committee prior to the end of 1st quarter, 2014. Safety Committee will be responsible for scheduling fire drills sequencing in accordance to regulations.Staff member Responsible: Safety Officer and Appointee(s) from</p>	12/31/2013			

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	<p>facility and offsites for calendar year 2012, indicated there was no fire drills conducted for the Avon Medical Building and HRH YMCA offsites.</p> <p>3. In interview, on 10-30-13 at 9:15 am, employee #A7 confirmed the above and no further documentation was provided prior to exit.</p>		Safety Committee.		

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S001216	<p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(b)(1)(A)(B)(i)(ii)(iii)(iv)(v)(C)</p> <p>(b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows:</p> <p>(1) Proper safety precautions shall be maintained against radiation hazards in accordance with the hospital's radiation and safety program as developed by the radiation safety officer. This includes, but is not limited to, the following:</p> <p>(A) Adequate shielding for patients, personnel, and facilities. (B) Procedures for monitoring: (i) skin dosage; (ii) radionuclide contamination; (iii) quality control; (iv) technique charts, where applicable; and (v) handling of hazardous materials. (C) Appropriate storage, use, and disposal of radioactive materials.</p> <p>Based on observation, interview, and policy review, the radiology department failed to follow their policy regarding storage of the radiation monitoring equipment to ensure personnel safety.</p> <p>Findings included:</p> <p>1. During the tour of the radiology department at the facility's off-site</p>	S001216	This policy was written to specifically address a film based personal monitoring system. During review of this policy this statement apparently was overlooked as Hendricks Regional Health has switched entirely to an Optically Stimulated Luminescence (OSL) personal monitoring system provided by Landauer Corporation. This move was made specifically to	11/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/30/2013
NAME OF PROVIDER OR SUPPLIER  HENDRICKS REGIONAL HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 E MAIN ST DANVILLE, IN 46122		
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	<p>medical building at 10:30 AM on 10/29/13, accompanied by staff members #P1, P3, and P22, no central or designated storage area was observed for the radiation monitoring equipment.</p> <p>2. At 10:35 AM on 10/29/13, the director of the department, staff member #P22 indicated he/she was unsure of where the badges were stored, but thought staff took them home with them.</p> <p>3. The facility policy "Safety and Equipment", last reviewed 7/26/13, indicated, "D. Monitoring Radiation Exposure: 1. All physicians and personnel working in areas using radiation shall wear radiation-monitoring equipment (film badge). At no time shall a film badge be exposed to radiation unless worn by the individual to whom it is issued. 2. Distribution and collection of film badges shall be the responsibility of the Coordinator. It is the responsibility of the authorized user, physician, or department manager to insure the cooperation of personnel under his or her supervision. ...4. Film badges shall be stored in associates' locker or mailbox in the department. Film badges are not to be taken out of the hospital."</p>		<p>decrease many of the issues surrounding the usage of a film based personal monitoring system such as environmental issues, exposure to excessive moisture, and sensitivity to heat. The OSL system provides a much more stable system in addition to being able to measure lower exposure levels. Advantages of OSL systems may be seen in a presentation entitled Optically Stimulated Luminescence (OSL) dosimetry in radiotherapy by Joanna E. Cygler and Eduardo Yukihiro. As there are no specific regulations for the handling of personal monitoring devices at either the Federal or State level, item D4 has been removed from Monitoring Radiation Exposure. A letter from Medical Physics Consultants Inc. supporting this action has been uploaded. Please refer to "S1216 MPC Letter"</p>		