

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 02/22/2012
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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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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005005</p> <p>Survey Date: 2-20/22-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 03/05/12</p>	S0000	HRH acknowledges receipt of the reports. - Matthew Browning Director, Quality Resource Management	

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

TITLE

(X6) DATE

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

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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 1 contracted service.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the governing board minutes year 2011 indicated they did not include review of reports for the contracted bioengineering service. 2. On 2-22-12 at 10:15 am, upon interview, employee #A9 indicated no reports for the above service was reviewed by the governing board in year 2011 and no further documentation was provided prior to exit. 	S0270	<p>Each year, the Quality Resource Management department facilitates an organization wide contract review process in which it solicits input into the performance of contracted vendors per their contracts. Elements of this review include: · Management, staffing and support personnel are qualified, reliable and competent, with appropriate licensure and certification. · Contract service complies with all applicable quality improvement, infection control, safety, risk management, etc., hospital policies. · Service provided is cost effective and efficiently administered. · Patient satisfaction is consistent expectation. · Management and the contract service complies with all terms of the agreement. · If applicable, the Director of Information Systems has</p>	03/12/2012	

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			<p>evaluated the services of the company and found them acceptable. · If applicable, a current insurance certificate naming HRH as an additional insured is maintained in file. · There is no conflict of interest between the hospital and the other party that would harm the hospital's mission. · The contract service complies with all HIPAA privacy and security guidelines to protect patient confidentiality. Unfortunately at the time of the 2011 evaluation, the responsible party of the department that includes the contracted bioengineering service was on medical leave and therefore was unable to provide review of that service. On 3/12/2012, the contract review form was turned into the QRM department for the Bioengineering service indicated in the survey results; the vendor being Diversified Instruments Services.. Additionally, the results of the survey will be included in the April, 2012 report to the Board of Directors. Moving forward, the QRM department will ask each department director to identify a secondary contact within the department to contact in the case that the Director is unavailable to fill out the annual contract review.</p>		

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S0406	<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.</p> <p>Based on document review and interview, the hospital failed to include monitors and standards for 1 service provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted service of bioengineering.</p> <p>2. On 2-22-12 at 10:15 am, upon interview, employee #A9 indicated there was no documentation for the above activity and none was provided prior to exit.</p>	S0406	<p>As indicated on the response to S 0270, the Vendor in question was HRH's bioengineering cleaning vendor - Diversified Instruments Services (DIS). As of 3/12/2012, two sets of indicators have been developed to continuously monitor the services provided by DIS. As indicated in the response to S 0270, DIS will be evaluated on an annual basis as part of HRH's annual contract review survey. The included survey elements that DIS will be evaluated against will be:- Does Management, staffing and support personnel are qualified, reliable and competent, with appropriate licensure and certification?- Does the contract service compile with all applicable quality improvement, infection control, safety, risk management, etc., hospital policies?- Is the service provided cost effective</p>	03/12/2012			

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			and efficiently administered? - Does the vendor ensure that patient satisfaction is consistent delivered? - Does HRH Management and the contract service comply with all terms of the agreement? - If applicable, has the Director of Information Systems has evaluated the services of the company and found them acceptable? - If applicable, is there a current insurance certificate naming HRH as an additional insured is maintained in file? - Does the service provided have any conflict of interest between the hospital and the other party that would harm the hospital's mission? - Does the contracted service comply with all HIPAA privacy and security guidelines to protect patient confidentiality? Additionally, HRH Engineering, beginning in 4/1/2011, led by the director of engineering will include performance metrics to ensure that DIS is meeting its obligation to ensure good service. After discussion with HRH engineering, the measure for this activity will be semi-annual percentage of instruments calibrated by DIS in the control system. Initial goal is 90%. This will be reported to both Safety Committee and Quality Steering Committee at least bi-annually.		

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S0554	<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 document review, interview and observation, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients and health care workers for 1 offsite and 1 cardiac cath lab.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the manufacturer's recommendations for the enzymatic cleaner indicated that 1/2 ounce of enzymatic cleaner per 1 gallon of water. On 02-21-12 at 1400 hours, staff #50 confirmed that he/she uses a handful of enzymatic cleaner when mixing with water. Review of policy/procedure Hendricks Regional Health Organization - Wide Bloodborne Pathogens Exposure Control Plan indicated the following; "5. Policy for Methods of Compliance, PPE a) All PPE is utilized on task assessment 	S0554	<p>Based on observation, on 2/22/2012, the Director of Central Sterile met one on one with employee and provided overview training and counseling about the proper way to mix the enzymatic cleaning solution with water. Additionally, education was posted around the unit to ensure that all staff members were made aware of the proper procedure for mixing the enzymatic cleaning solution and water. Please refer to uploaded copy of posting (File: S0554.pdf). Cardiac Cath Lab Response: The staff member that was observed not wearing PPE during the procedure was an affiliated physician on HRH's Medical Staff. As such, the Vice President of Medical Affairs met one on one with physician on 2/24/2012 and explained the regulatory requirement for use of PPE in the Cardiac Cath Lab. The physician indicated that they understood the requirement and would ensure that proper PPE use was maintained in the future. Additionally, on 2/24/2012 Cardiac Cath personnel have posted reminder posters in the unit that the use of proper PPE is</p>	02/22/2012			

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	<p>i) Generally, PPE should be used for those tasks where the possibility for exposure to blood or Other Potentially Infectious Materials (OPIM) exists.</p> <p>d) PPE includes but is not limited to: iii) Face and eye protection"</p> <p>This policy/procedure was last reviewed/revised on 02/2010.</p> <p>4. During the facility tour of the Cardiac Cath Lab on 02-21-12 at 1130 hours the following was observed: 1 staff member performing the cardiac cath procedure without protective eye wear on.</p>		<p>mandated at all times.ADDENDUM:For monitoring purposes, all employees are required to take PPE competency training once a year via a Healthstream education module. Comptency completion rates are reported annually from the Education department to the QAPI program.Additionally, to ensure that central sterile staff continue to use proper mixing procedures for the enzymatic cleaning solution, unit management will perform spot checks with staff and report results to the QAPI program.</p>	

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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and interview, the facility failed to ensure that nursing personnel follow established standards of nursing care for 6 of 8 medical records (MR) reviewed (Patient # 9, 16, 18, 19,</p>	S0912	Patient #9 was seen in the Emergency Room (ED) where documentation is entered in the IBEX software system. This system records both the time of documentation entry and text of	03/15/2012			

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	<p>21 and 24).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Pain Management indicated the following on page 2; "E. Reassessment will be performed according to type of pain and level of effectiveness regarding medication and / or treatment intervention utilized.</p> <p>2. Reassessment of pain will occur at time of expected relief of intervention or based upon standard of care for pharmacological interventions.</p> <p>G. Reassessment will include at minimum:</p> <p>1. Pain intensity 2. Pain quality 3. Response to treatment interventions"</p> <p>This policy/procedure was last reviewed/ revised on 12/10.</p> <p>2. Review of patient #9's MR indicated the patient received medication for pain on 02-02-12 at 0448 hours and 0507 hours and the patient's MR lacked documentation of a reassessment of the pharmacological interventions.</p> <p>3. Review of patient #16's MR indicated the patient received medication for pain on 11-09-11 at 0231 hours and the patient's MR lacked documentation of a</p>		<p>any change from that time to a different time of administration to the patient. The dose listed at 0507 reflects the documentation time with the actual patient receipt of pain medication at 0410. Pain assessment/reassessment in the ED is recorded on the vital sign flow sheet and this specific reassessment is present at 0448. The reassessment was within 30 minutes of administration with no correction required. (Please refer to uploaded file S0912.pdf).The listed 0448 dose was given at 0448 (no text notation records a variance.) The acute patient was in transport to S. Vincent Heart Center for specialized care 7 minutes after the dose was given. This dose was given for pain management during transfer to a qualified clinical provider able to reassess and/or re-medicate during 0455 ambulance transport. (Please refer to uploaded file S0912.pdf). The ED Director has used Just Culture in discussing clarity of documentation and is re-educating staff on documentation/accuracy of actual times and documentation of patient pain status at discharge by 3/15/12. The Director will monitor discharge pain reassessment on all acute transfers from the ED in Monthly Pain Management audits. These audits are a Quality Indicator in the ED for 2012 with feedback to</p>		

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	<p>reassessment of the pharmacological interventions.</p> <p>4. Review of patient #18's MR indicated the patient received medication for pain on 01-09-12 at 1430 hours and the patient's MR lacked documentation of a reassessment of the pharmacological interventions.</p> <p>5. Review of patient #19's MR indicated the patient received medication for pain on 01-12-12 at 1016 hours and the patient's MR lacked documentation of a reassessment of the pharmacological interventions.</p> <p>6. Review of patient #21's MR indicated the patient received medication for pain on 12-30-11 at 0718 hours and the patient's MR lacked documentation of a reassessment of the pharmacological interventions.</p> <p>7. Review of patient #24's MR indicated the patient received medication for pain on 01-15-12 at 1157 hours and the patient's MR lacked documentation of a reassessment of the pharmacological interventions.</p> <p>8. On 02-22-12 at 1325 hours, staff #49 confirmed that patient #9, 18, 19, 21 and 24's MR lacked documentation of a</p>		<p>staff by the Director and Clinical Manager through department postings and staff meetings. The Just Culture approach will be used with staff for any deficiencies noted.ADDENDUM:For clarification, Nursing directors will monitor ALL pain reassessments. Additionally, one week after the state visit, Hendricks Regional Health migrated over to a new inpatient electronic health record. This new EHR has logic built into the system to prompt for pain reassessments and will help to ensure that reassessments are occurring per hospital policy.</p>		

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	reassessment after receiving pharmacological interventions.				

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S0952	<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).</p> <p>Based on review of approved medical staff policies and procedures, review of transfusion records, and staff interview, the facility failed to administer one of seven blood transfusions reviewed according to the approved Blood/Blood Product Administration policy/procedure.</p> <p>Findings included: 1. On 2/20/12, review of a policy/procedure labeled: "HENRICKS REGIONAL HEALTH NURSING DEPARTMENT, BLOOD/ BLOOD PRODUCT" revealed: PROCEDURE: V. Patient Assessment Parameters: B. Vital Signs Assessment - 1. Vital signs will be assessed within 15 minutes prior (PRE vitals) to administering the blood/blood product to establish a baseline by an RN only." 2. On 2/21/12 between 10:00 a.m. and 11:00 a.m., review of Transfusion Record</p>	S0952	<p>The patient in question was admitted to the Surgical Unit from the Emergency Department at 0230. The blood was released from Blood Bank at 0346 and transfusion began at 0400 under a signed consent. Pre-transfusion vital signs were taken and recorded after admission to the unit, with an update verified by the Unit Director as done at 0400 on the vital sign record of the patient chart (within 15 minutes of starting the transfusion as required by policy), however the time was recorded on the manual transfusion record in error as 0300, not 0400. Using Just Culture, on 3/8/12 the Director provided re-education on the policy criteria and the need for accuracy of documentation to the transfusion record to the two nurses starting the transfusion. Effective 3/1/12, the manual transfusion documentation transitioned to Meditech 6.0 for</p>	03/01/2012	

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	<p>cp#2 revealed the PRE vitals were performed at 0300 and the transfusion was started at 0400.</p> <p>3. In interview during the above Transfusion Record review, staff persons cp#1 and cp#2 acknowledged Transfusion Record #cp2 the PRE vitals were not performed 15 minutes prior to administering the blood.</p>		<p>computer entry of the process. All checks for scanning and documentation of fluid intake are required. Once a transfusion start vital sign is documented, reminders appear for documentation of the remaining elements of the process are mandatory for record completion. Monthly audits by Blood Bank continue to be reviewed by the hospital Transfusion Committee and blood transfusions are a Quality Indicator on all nursing units. This team evaluates need for policy changes and/or staff education. Just Culture is used by the Directors in follow up discussions with staff based on monthly audits.</p>	

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S1118	<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 observation, the hospital created a condition which resulted in a hazard to patients, public or employees in 1 instance.</p> <p>Findings:</p> <p>1. On 02-21-12 at 9:50 am in the presence of employee #A8, it was observed in the maintenance garage area, there was 1 fire extinguisher on the floor unsecured by chain or holder.</p> <p>2. If the above extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p>	S1118	<p>During the survey visit, a fire extinguisher was discovered unsecured in the maintenance garage at the HRH main campus garage. The fire extinguisher discovered in the maintenance garage area was a contractor piece of equipment left behind after completion of a renovation project. The extinguisher was immediately secured properly, placed in storage racks with spare extinguishers, and will be given to the planned maintenance contractor for recovery of gas and disposal of tank. Additionally, a memo will be sent to all vendors reminding them that all fire extinguishers must be secured at all times. HRH security will continue to monitor fire extinguishers during their rounds at all HRH locations to ensure that this issue is not repeated.</p>	02/22/2012	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1166	<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.</p> <p>Based on observation, document review and interview, the hospital failed to keep appropriate records pertaining to equipment maintenance for 1 piece of equipment.</p> <p>Findings:</p> <p>1. On 2-20-12, in the presence of employee #A8, it was observed in a cabinet in the Occupational Therapy room, there were several Jaymar Sammons Preston Rolyan handymanometers. One of the devices, serial number 31007255, had a label which indicated remember to calculate regularly for accurate data and long life.</p> <p>2. Hospital staff was requested to provide the above documentation for the particular device.</p>	S1166	During survey on 2/20/12, it was discovered on a tour of the HRH PT department that a hand dynamometer did not have preventative maintenance records. After further review, all hand dynamometers have been inventoried at all hospital locations. To ensure on-going maintenance of this equipment, these instruments will be added to the electronic Maintenance Management System and an annual calibration performed on a sequential schedule.	03/08/2012			

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	3. On 2-22-12 at 10:30 am, upon interview, employee #A8 indicated there was no documentation and none was provided prior to exit.			