

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/06/2013
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH MORGAN HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 JOHN R WOODEN DR MARTINSVILLE, IN 46151
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005036</p> <p>Survey Date: 11-4/6-13</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/'22/13</p>	S000000		

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

TITLE

(X6) DATE

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

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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 3 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for 3 contracted laboratory services.</li> <li>2. In interview, on 11-6-13 at 11:15 am, employee #A2 confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S000270	<p>S – 0270: 1). Plan of correction:S -0270: The IU Health Morgan Hospital Performance Improvement Plan has been updated to include contracted services. Service lines within the hospital will monitor quality standards for contracted services as determined by the department leader. This plan will include the a). The standard of the service provided, b). The quality measurement, c). The list of criteria, c). The method of tracking, d). The documented action plan if standard not met. This information will then be submitted to the Quality department for review and areas indicated with a performance improvement component will then be reviewed by the Clinical Process Improvement Committee. Contracted service measures will be submitted to the</p>	12/05/2013	

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S000308	<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. Based on personnel file review and interview, the facility failed to ensure all</p>	S000308	<p>governing board on a quarterly basis. Policy update completion date: 12-05-2013.2). Prevention of recurrence: Education provided to department leaders per review of updated policy on 12-5-2013. Vice President of Service Excellence (includes Quality &amp; Process Improvement) will assess data as documented in Performance Improvement Plan on a monthly basis. The expectations regarding contracted services quality data monitoring has been shared with department leaders. 3). Responsibility: The VP of Service Excellence who oversees Quality is responsible for submitting data to the governing board on a quarterly basis.</p> <p>S – 0308: 1). Plan of correction: S-0308: The policy regarding onboarding of</p>	11/27/2013	

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	<p>staff received initial departmental orientation in 10 of 15 staff files reviewed (P1, P2, P3, P4, P7, P8, P11, P12, P13, and P14).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The personnel file for RN (Registered Nurse) P1, hired 07/09/12, indicated an incomplete 9-page Orientation Summary form that also lacked signatures, dates, and times of the employee and director.</li> <li>The personnel file for RN P2, hired 02/21/11, indicated an incomplete 9-page Orientation Summary form that also lacked the signature, date, and time of the employee.</li> <li>The personnel file for RN P3, hired 07/09/12, indicated a single page Nursing Orientation Checklist, dated 07/11/12, but not signed by any preceptor or director to indicate completion.</li> <li>The personnel file for RN P4, hired 05/18/09, indicated a 9-page Orientation Summary form without a complete date anywhere, including with the signatures of the employee and the director.</li> <li>The personnel file for LPN (Licensed</li> </ol>		<p>new employees has been updated to include the requirement for department specific orientation requirements. The completion of this updated policy: 11/27/2013. Department leader education was also provided on 11/27/2013. 2). Prevention of recurrence: Employee files will periodically be audited by the Department Leaders to ensure completion of all department-specific orientation and forms completion. 3). Responsibility: Vice President of Human Resources</p>		

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	<p>Practical Nurse) P7, hired 10/17/11, indicated a 9-page Skills Self Assessment form with numerous zeros indicating "I have no experience" that lacked signatures of the employee and director. This form was provided as the orientation document.</p> <p>6. The personnel files for staff members P8, hire date 05/24/07, P13, hire date 08/20/07, and P14, hire date 09/15/08, lacked documentation of initial departmental orientation.</p> <p>7. The personnel file for patient care tech P11, hired 02/04/13, indicated successful competency of 5 specific skills, but no complete initial departmental orientation.</p> <p>8. The personnel file for surgical tech P12, hired 03/18/13, indicated a 3-page checklist, initialed by the employee, but not signed by a preceptor or director and with no complete initial departmental orientation.</p> <p>9. At 3:15 PM on 11/05/13, staff member A6 confirmed the incomplete or lacking orientation documentation in the employee files.</p>			

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S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation, policy and procedure review, interview, and national guidelines, the facility failed to follow the standard of practice for home laundering of surgical attire.</p> <p>Findings included:</p> <p>1. During the tour of the surgical department at 12:15 PM on 11/04/13, accompanied by staff member A12, staff members, including surgical tech #A13, were observed wearing reusable, cloth hair coverings.</p> <p>2. The facility policy "Operating Room Attire", last revised on 08/13 and based on AORN (Association of Perioperative</p>	S000608	<p>S – 0608: 1). Plan of correction: S-0608: The Operating Room Attire policy was updated to include the required the operating room staff to wear the standard disposable head covering while in the operating room. Policy completion and staff education completion date: 11/18/2013.2). Prevention of recurrence: Education regarding the updated Operating Room Attire policy was provided to all operating room staff.</p> <p>The department director will monitor the use of the required disposable head coverings as required by the policy. 3). Responsibility: Vice President of Patient Care Services, CNO</p>	11/18/2013			

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	<p>Registered Nurses), indicated, "A. Apparel- Operating Room apparel is as follows: ...2. Coverall suites when available (a) Surgical caps may be disposable or (b) Reusable. If reusable, they should be laundered after wearing and dried in a dryer to remove lint."</p> <p>2. At 12:25 PM on 11/04/13, the director of surgery, staff member A12, indicated a lot of the surgical staff wear their own cloth hats and launder them at home. He/she confirmed the department followed AORN standards.</p> <p>3. Review of the 2010 Perioperative Standards and Recommended Practices by AORN regarding laundering of surgical attire indicated, "7. Home laundering of surgical attire is not recommended. Without clear evidence about the safety for patients, health care workers, and their family members, AORN does not support the practice of home laundering of surgical attire. Reusable surgical attire, including cover jackets and cloth hats, should be laundered by a designated facility-approved and monitored commercial laundry after daily use."</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 policy/procedure review, transfusion record review, and staff interview, the facility failed to follow an approved medical staff policy/procedure for the administration of three of six transfusions reviewed.</p> <p>Findings include: 1. On 11/4/13 review of a policy/procedure titled: "Morgan Hospital, BLOOD ADMINISTRATION, ALL COMPONENTS, (INCLUDING UNFILTERED, PLATELET AND CRYOPRECIPITATE) ADMINISTERED WITH FILTERED TUBING, ADAPTER &amp; ADMINISTRATION SET" which stated: "C. Implementation 2. Take the patient's vital signs (Temp, pulse, respirations, and BP (blood pressure) no more than 30 minutes prior to starting the unit to establish pre-transfusion</p>	S000952	<p>S- 0952: 1). Plan of correction: S-0952: The IU Health Morgan Blood Administration policy has been updated to reflect appropriate timing of pre-transfusion vital signs now required prior to obtaining blood from blood bank, assessing patient for flank/back pain and/or hematuria, prior to transfusion, education of patient and family regarding purpose of transfusion and resolution of questions prior to requesting of blood components. The education department has also updated new employee orientation for nurses to include review and demonstration of the blood administration process per the policy. Ongoing education will also be provided by department leaders as necessary and appropriate. Policy completion date: 11/27/2013. Education to staff completed 11/27/2013.2). Prevention of recurrence: Audits will</p>	11/27/2013			

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S001168	<p>vitals." and "7. Set desired rate.....(to infuse within 4 hours from the time the unit is released from the blood bank.)"</p> <p>2. Transfusion record review indicated: T#2 was started at 1606 and the previtals were taken at 1606, not following policy/procedure. T#4 was started at 1435 and the previtals were taken at 1435, again not valid previtals and not following policy/procedure. T#5 was removed from the blood bank at 1033 and stopped at 1449 which exceeds the 4 hour time limit. This transfusion was actually stopped for a time due to chills and a called possible reaction, but restarted and completed.</p> <p>3. In interview on 11/5/13 at 1:00 p.m. staff person #cp 8 acknowledged the above data and the policy/procedure is not being followed as written.</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 hospital failed follow the</p>	S001168	<p>be performed on all blood administration documentation to assess for compliance.3). Responsibility: Vice President of Patient Care Services, CNO</p> <p>S – 1168: 1). Plan of correction: S-1168: The defibrillator checklist has been</p>	12/01/2013			

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	<p>manufacturer's recommendation to periodically test its defibrillator and did not properly keep a discharge log for 1 of 1 defibrillator.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the Zoll M Series Defibrillator Manual, the defibrillator used by the hospital, indicated the following operations checks should be performed at the beginning of every shift to ensure proper equipment operations and patient safety. Refer to the appropriate Operator's Shift Checklist at the end of this section.</li> <li>2. Review of a document entitled Operator's Shift Checklist for M Series Products (Semi-Annual) indicated various checks to be conducted including, but not limited to Condition, Paddles (if applicable) and Inspect cables for cracks, broken wires, connector. only the procedure to test the defibrillator.</li> <li>3. Review of a hospital policy entitled EMERGENCY EQUIPMENT CHECKS, revision date 1/12, indicated it did not include the above-stated checks in the Operator's Shift Checklist for M Series Products (Semi-Annual).</li> </ol>		<p>updated to reflect the manufacturer's guidelines. There are now separate checks for the defibrillation, pacing, and sync functions. The checklist refers to the manufacturer's guidelines. The "Emergent Equipment Checks" policy will reflect changes in the documentation practice; including an addendum of the manufacturer's guidelines. All nurses have received education from their clinical directors. Policy completion date: 11/26/2013. Staff education completed &amp; implementation date: 12/01/2013. 2). Prevention of recurrence: Department Directors will provide on-going monitoring/auditing. Departmental tracers will spot check. On-going educational reminders will be provided in department meetings.3). Responsibility: Vice President of Patient Care Services, CNO</p>		

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	<p>4. Review of a document entitled Code Cart Checklist, Year 2013, Month Oct, Unit: ICU, indicated it did not include the above-stated checks in the Operator's Shift Checklist for M Series Products (Semi-Annual).</p> <p>5. In interview, on 11-6-13 at 2:15 pm, employee #A1 confirmed the above and no other documentation was provided by exit.</p>			