

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005064</p> <p>Dates: 7-22-13 through 7-23-13</p> <p>Surveyors: Billie Jo Fritch, RN, MBA, MSN Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratory Surveyor</p> <p>QA: claughlin 07/30/13</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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S000592	<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, observation, and interview, the facility failed to ensure a sanitary environment was maintained within the surgery department.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Label instructions for SUPERGARD cleaner/disinfectant/deodorizer states "Allow surfaces to remain wet for 10 minutes." 2. Review of surgical patient records indicated the appropriate time was not allowed for the disinfectant to be effective between patients as follows: (A) Patient #7 had surgery on 7/9/13 and left OR #2 at 7:40 a.m. 	S000592	1, 2 & 3) Operating Nurse Manager verbally informed (7-23-13) OR staff on day of SBOH survey that Superguard must be left on OR surfaces x10 minutes per policy (see Attachment A). Infection Control Nurse will be present at August 20, 2013 OR staff meeting to provide formal re-education on the use of Superguard, review the policy and answer questions. The Superguard representative will also address re-education of the OR staff during the OR staff meeting. The Housekeeping Supervisor has ordered buckets for Superguard; when received, the Superguard will be applied via wipe on cloth instead of spray. OR Nurse Manager will review the correct process for using Superguard per policy	08/20/2013	

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S000754	<p>(B) Patient #8 had surgery on 7/9/13 and entered OR #2 at 7:45 a.m.</p> <p>2. During tour of the surgery department beginning at 10:40 a.m. on 7/23/13, the following was observed: (A) RN #1 was observed spraying SUPERGARD disinfectant on surfaces after an EGD and Peg tube placement procedure. He/she immediately wiped the product off with a towel.</p> <p>3. RN #1 indicated in interview at the time of the observation that the kill time for the product to work was "right on."</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on review of the Informed Consent Transfusion policy,</p>	S000754	(Attachment A) with OR staff during monthly OR staff meetings. Effective August 20, 2013 and ongoing.			09/30/2013	

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	<p>patient medical records and staff interview, the hospital failed to complete documentation for evidence of informed consent using procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law for one of ten patients receiving blood.</p> <p>Findings include:</p> <p>1. On 7/22/13 at 12:30 p.m., the policy, "Informed Decision Making/Consent for Treatment", policy 5.14, approved 3/29/13, read: "Witnesses must always sign in the space allocated on the form as witness to the signature of the person signing the form."</p> <p>2. On 7/22/13 at 12:45 p.m., review of one patient receiving two blood units revealed that</p>		<p>informed by the Med Surg Nurse Manager (8-8-13) during nursing staff meetings (Attachment C, page 3) on August 8, 2013, that the witness signature on the consent must be completed prior to presenting the consent to the Laboratory to obtain blood. Laboratory staff has been informed by memo from the Laboratory Director (8-6-13) that lab technologists/technicians must verify the completed consent form prior to issuing any blood component to nursing staff (Attachment D). Re-education has also taken place for lab employees during the 8-9-13 lab staff meeting (Attachment E, page 2). A mandatory educational inservice will be held on September 30, 2013 for all RNs in ER, Oncology, OB, ICU and Med Surg (Attachment F). The Laboratory Director will monitor (quarterly and ongoing) the completion of consents for blood components (to include witness signature) and report results to the Quality Improvement Subcommittee. (Attachment G). Reports will then be forwarded to the Board of Trustees.</p>		

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	<p>both these received-units had each been administered without documentation of the witness's signature on the patient's consent, including:</p> <p>Patient #6 --Unit #61 administered on 7/10/13 at 1940 --Unit #62 administered on 7/11/13 at 0145</p> <p>3. On 7/22/13 at 1345, staff member #10 indicated the occurrence of the above-listed missing consent witness documentation.</p>				

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S000868	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed:</p> <p>(i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff;</p> <p>(ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or</p> <p>(iii) within forty-eight (48) hours after an admission.</p> <p>Based on document review and staff interview, the facility failed to ensure a history and physical (H&P) was conducted per Medical Staff Bylaws for 2 of 2 patients undergoing cataract surgery.</p> <p>Findings include:</p> <p>1. Medical Staff Bylaws last approved 9/11/12 states on page 3: "(18) A complete history and physical examination shall, in all cases, be completed and on the chart no more than seven (7) days before or 24 hours after</p>	S000868	1, 2, 3 & 4) A memo from the Chief of Surgery (Attachment H) (8-6-13) has been sent to all surgeons outlining the requirement for history and physicals per Medical Staff Bylaws, with special emphasis on current/updated H&Ps prior to surgery. A copy of the Medical Staff Bylaws which addresses this requirement was also sent to all surgeons (Attachment I, page 3 of 9). The OR policy 'Pre-op History and Physicals and Informed Consent' has been revised (8-12-13) (Attachment J) to include the requirement for updated H&P prior to surgery.	09/10/2013

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	<p>admission. When the history and physical is completed within 7 days of admission, an updated medical record entry documenting the repeat physical examination is added to the original H&P and entered into the medical record with 24 hours after admission and prior to any surgical procedure."</p> <p>2. Review of patient #7 medical record indicated the following: (A) He/she had cataract surgery on 7/9/13. (B) His/her H&P was dated 6/12/13 with no update made.</p> <p>3. Review of patient #8 medical record indicated the following: (A) He/she had cataract surgery on 7/9/13. (B) His/her H&P was dated 6/12/13 with no update made.</p> <p>4. Staff member #10 verified the above beginning at 2:45 p.m. on 7/23/13.</p>		The revised policy will be forwarded to the Medical Staff for approval during it's September 10, 2013 meeting. Re-education of OR staff regarding revised policy will occur in the August 20, 2013 OR staff meeting. OR staff will monitor compliance with policy by concurrently monitoring 30 surgery charts per quarter (quarterly and ongoing). Results will be reported to the Quality Improvement Subcommittee quarterly (Attachment K) and forwarded to the Board of Trustees.		

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and staff interview, the nurse executive failed to ensure the nursing department notified the patient's physician of critical lab values for 1 of 2 critical care patients.</p>	S000912	1 & 2) Nursing policy titled 'Critical Lab Values - Notification of Physician' has been written by the Vice President of Nursing Services (Attachment L) (8-6-13). Education of nursing	08/06/2013			

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S000952	<p>Findings include:</p> <p>1. Review of patient #11 medical record indicated the following: (A) He/she had a critical high Troponin level of 0.180 (normal range 0.012-0.034) at 4:25 a.m. on 5/23/13. (B) The medical record lacked documentation that nursing notified the physician of the critical high lab result. The medical record lacked evidence that the physician was aware (i.e. review of progress notes etc.)</p> <p>2. Staff member #10 verified the above beginning at 2:45 p.m. on 7/23/13.</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).</p> <p>Based on blood transfusion policy review, transfusion document chart reviews and staff interview, the hospital</p>	S000952	<p>staff regarding reporting requirement and policy took place via memo from Vice President of Nursing Services on 8-6-13 (Attachment M) and during nursing staff meeting held 8-8-13 by Med Surg Nurse Manager. (Attachment N, page 3). The ICU Nurse Manager will audit 30 charts/quarter for compliance (Effective 3rd Quarter, 2013 & ongoing) on timely reporting of critical lab values to physician. Results will be reported quarterly to the Quality Improvement Subcommittee (Attachment O) and forwarded to the Board of Trustees.</p> <p>1, 2 & 3) Laboratory/Nursing policy titled 'Blood and Blood Component Transfusion' has been revised to clarify that blood will be returned to Lab if not infused within 4 hours from time</p>	09/30/2013			

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	<p>failed to administer blood transfusions in accordance with approved medical staff policies and procedure for two of ten patients.</p> <p>Findings include:</p> <p>1. On 7/22/13 at 1230, the policy "Blood and Blood Component Transfusion", effective 3/12/13, read: "A unit of blood must not transfuse longer than four (4) hours."</p> <p>2. On 7/22/13 at 1245, review of two patients receiving two blood units, did not have complete documentation, per policy, on the Transfusion Record sheet including:</p> <p>Patient #3 --Unit #31 administered on 6/27/13 at 0030: The unit was released from the blood bank at 0007 and completed at 0430 which was 4 hours and 23</p>		<p>of issue (Attachment P, page 3). Nursing staff informed via memo (Attachment Q) from Vice President of Nursing on 8-6-13 and re-educated by Med Surg Nurse Manager during the August 8, 2013 nursing staff meeting (Attachment N, page 3) that blood is to be returned to lab if not infused within 4 hours from time of issue. A memo (Attachment R) was sent (8-6-13) by the Lab Director to all Lab staff that blood transfusions must be completed in 4 hours or less from time of issue from Lab. This requirement was also addressed with lab staff during the 8-9-13 Laboratory staff meeting (Attachment E, page 2). A mandatory inservice for appropriate staff will be held by the Education Coordinator regarding the transfusion of blood and blood components (Attachment S). Completion date for the inservice is 9-30-13. The Lab Director will audit 30 charts/quarter for compliance with blood transfused within 4 hours from time of issue. Results will be forwarded to the Quality Improvement Subcommittee (Attachment T) quarterly and forwarded to the Board of Trustees.</p>	
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	<p>minutes in lieu of within 4 hours.</p> <p>Patient #8 --Unit #81 administered on 7/19/13 at 1800: The unit was released from the blood bank at 1734 and completed at 2145 which was 4 hours and 11 minutes in lieu of within 4 hours.</p> <p>3. On 7/22/13 at 1345, staff member #10 indicated the two above-listed patients had been administered blood units greater than 4 hours.</p>			