

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150101		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011	
NAME OF PROVIDER OR SUPPLIER PARKVIEW WHITLEY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1260 E SR 205 COLUMBIA CITY, IN 46725			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005090</p> <p>Survey Dates: 11-15-11 to 11-17-11</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Lynnette Smith, BS MLT (ASCP) Medical Surveyor</p> <p>QA: claughlin 12/05/11</p>			S0000			

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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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</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: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to ensure that all services update and/or review all policies and procedures at least triennially.</p> <p>Findings:</p> <p>1. The policy/procedure Procedure Formulation (last reviewed 10-08) indicated the following: Procedures shall be scheduled for review every three years in accord with the approval effective date, to evaluate the continued applicability of the procedure. Procedures shall be revised as appropriate and revisions must adhere to the necessary review and approval processes. The policy/procedure failed to indicate that it had been reviewed within the past three years.</p> <p>2. On 11-17-11, requested</p>	S0322	<p>Prefix Tag: Tag S 322 – Governing Board /P&P Rad/Nuclear A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>A policy and procedure scheule was implemented for the Diagnostic Imagaing Manager to review all diagnostic imaging policies and procedures. All revisions and approvals will be completed as outlined in the schedule.</p> <p>B. How are you going to prevent the deficiency from recurring in the future?</p> <p>A policy and procedure schedule was developed on 12/17/2011 and is monitored by the Manager to ensure that all policies and procedures are current.</p> <p>C. Who is going to be</p>	12/17/2011

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	<p>policy/procedures including nuclear medicine and radiology failed to indicate that an update or review had been performed within the last three years.</p> <p>3. On 10-17-11 at 1020 hours, staff #A15 confirmed that the departmental policy/procedures had not been updated or reviewed within the last three years.</p>		<p>responsible for steps "A" and "B" above?</p> <p>The Diagnostic Imaging Manager has oversight and is accountable for this process.</p> <p>D. By what dates are you going to have the deficiency corrected? 12/17/2011.</p>	

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S0394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 20 contracted services.</p> <p>Findings:</p> <p>1. On 11-15-11 at 1445 hours, a list of all contracted services was received from staff #A2. The list of services failed to indicate a service provider for anesthesia equipment, biohazardous waste removal, elevator maintenance, exhaust hood testing, 2 fire services, generator service, housekeeping management and off-site housekeeping, kitchen management, laundry services, medical gas systems, pest control, medical physicist</p>	S0394	<p>Prefix Tag: Tag S 394 A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Administrative Contract Service Log will be updated to include all contract services and outline the scope and nature of each service. B. How are you going to prevent the deficiency from recurring in the future? All managers are required to inform administration of new contracted services and will ensure that the Administrative Contract Service Log is current. This process was reviewed with all managers on 12/12/2011. Quarterly facility inquiry and review will occur to ensure the list is accurate. C. Who is going to be responsible for steps "A" and "B" above? The COO has direct oversight and accountability for this process. D. By what dates are you going to have the</p>	12/17/2011

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	<p>consultants, radiology badge monitoring service, 2 sterilizer vendors, and 4 X-ray/CT/MRI equipment support services.</p> <p>2. Review of facility documentation indicated the following: anesthesia machine service by CS1 was performed 07-19-11, biohazardous waste management was provided by CS2, elevator service was performed by CS3, exhaust hoods were inspected by CS4 on 10-19-11, fire service providers included CS5 fire systems and fire panel monitoring by CS6, generator service by CS7 dated 10-27-11, housekeeping management by CS8, housekeeping services at one off-site by CS9, kitchen management by CS10, laundry service by CS11, medical gas systems by CS12, pest control by CS13, medical physicist calibration and inspection by CS14 dated 10-19-11, radiation badge testing by CS15, sterilizer service by CS16 and CS17, vacuum pump and compressor service by CS12 dated 09-19-11, X-ray equipment service by CS18 dated 04-25-11, CS1 service dated 10-24-11 and CS19 service dated 10-03-11, CT service</p>		<p>deficiency corrected? 12/17/2011.</p>	

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	<p>by CS1, MRI service by CS18 and Gamma Camera service by CS20.</p> <p>3. On 11-16-11 at 1650 hours, staff #A2 confirmed the list of contracted services failed to include the providers identified through facility documentation.</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 facility failed to include 20 contracted services in its Quality Assessment and Improvement (QA&I) program.</p> <p>Findings:</p> <p>1. The Parkview Safety and Quality Strategic Plan (approved 1-21-11) indicated the following: "The Parkview Safety and Quality Strategic Plan serves as the framework for clinical and non-clinical Safety and Quality activities...". The plan lacked a process ensuring that all non-clinical (including contracted) services would be provided in a safe and effective manner and are</p>	S0406	<p>Prefix Tag: Tag S 406 A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The list of contracted services was updated to include anesthesia equipment maintenance biohazardous waste removal, elevator maintenance, exhaust hood testing, fire services, emergency generator service, housekeeping, kitchen management, laundry services, medical gas systems support, pest control, medical physicist consultants, radiology badge monitoring, sterilizer providers, and diagnostic equipment services. As applicable, managers will establish metrics and evaluate the contracted services on a quarterly basis. All managers were informed of this process on 12/12/2011. B. How</p>	12/17/2011			

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	<p>included in the QA&I program.</p> <p>2. QA report cards failed to indicate ongoing monitoring for the contracted services of anesthesia equipment maintenance, biohazardous waste removal, elevator maintenance, exhaust hood testing, 2 fire services, emergency generator service, housekeeping management and off-site housekeeping, kitchen management, laundry services, medical gas systems support, pest control, medical physicist consultants, radiology badge monitoring service, 2 sterilizer providers, and 4 X-ray/CT/MRI equipment support services.</p> <p>3. During an interview on 11-17-11 at 1225 hours, staff #A2 confirmed that the 20 contracted services were not being monitored by the QA&I program.</p>		<p>are you going to prevent the deficiency from recurring in the future? Quarterly audits are conducted on the contracted services QA to ensure compliance. C. Who is going to be responsible for steps "A" and "B" above? The VP of Patient Care Services along with the COO has direct oversight and accountability. D. By what dates are you going to have the deficiency corrected? 12/17/2011.</p>		

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S0556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on employee health file review and staff interview, the infection control plan is not effective and clear in determining which staff members are at risk in the event of a communicable disease outbreak.</p> <p>Findings: 1. at 12:50 PM on 11/16/11, review of employee health files indicated: a. staff member P2 was hired 8/5/07 and had: I. an "equivocal" Rubeola titer result in the file II. a verbal/self report of having had Varicella as a child b. staff member P3 was hired 6/12/11 and had a negative titer for Rubella and Rubeola c. staff member P6 had a negative Rubeola and a note that the employee had "Declined Vaccine"</p>	S0556	<p>Prefix Tag: Tag S 556 A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Employee Health Services/Parkview Occupational Health is finalizing a new software report that will utilize an Excel spreadsheet format to track staff immunization status. The tool can be used to identify those who should be excluded from duty during an outbreak of Rubella, Rubeola, Varicella or Mumps. In the interim, if an outbreak should occur, each employee file will be reviewed to validate if they can or can not work as outlined in the infection control plan. B. How are you going to prevent the deficiency from recurring in the future? The new tracking report will be updated with each new hire and with all immunization status changes. In the event of an outbreak, Employee Health Services will be able to sort the report by facility, department, and</p>	12/17/2011			

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	<p>2. interview with staff member NH at 1:40 PM on 11/16/11, indicated:</p> <p>a. the facility is in the process of acquiring Varicella titers on all employees who self reported at the time of hire--this process began 2/11 and will take "approx. two years to complete"</p> <p>b. a computer print out can be produced that will indicate who is approved (immunity proven) to work in the event of a communicable disease outbreak within the community</p> <p>3. at 2:10 PM on 11/16/11, review of the computer print out (discussed with NH at 1:40 PM--see 2. above), indicated:</p> <p>a. staff member P2 had their Rubeola "equivocal" status noted on the print out</p> <p>b. staff member P3 had documentation on the form that the Rubella titer was negative, but Rubeola status is not listed (and was negative in the employee health file)</p> <p>c. staff member P6 had documentation of "0.60 Negative" and "No Immunity" noted on the form</p> <p>d. staff member P12 was noted as "0.97 equivocal" and "declination in chart (did not have vaccine)"</p> <p>e. staff member P13 had a "Rubeola 0.68 Negative" noted</p> <p>f. P14, P15, P16 and P17 all have "No immunization records found, No Lab records found" noted in their sections</p>		<p>staff member. C. Who is going to be responsible for steps "A" and "B" above? The Employee Health Services/Occupational Health Manager and the VP of Clinical Services have direct oversight and accountability. D. By what dates are you going to have the deficiency corrected?</p> <p>12/17/2011</p>	

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	<p>4. interview with staff members NA and NH at 3:45 PM on 11/16/11 and 9:00 AM on 11/17/11 indicated:</p> <p>a. the computer print out was supposed to indicate staff who could be utilized for staffing during an outbreak of either Rubella or Rubeola, but it also listed staff members who are negative or equivocal for those communicable diseases</p> <p>b. the list also had the names of staff who had no "immunization records or lab records" noted, making it a non-effective tool</p> <p>c. the infection control plan does indicate that non-immune staff will be off work between the 5th day of a known outbreak and the 21st day after the last known day of an outbreak, but the list provided by staff member NH would not be accurate for determining which staff could/could not work (based on their negative/equivocal status) during that time frame</p>			

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S0596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on staff interview, the infection control practitioner failed to observe or monitor the contracted housekeeping staff at one off site location, to determine that appropriate, hospital approved products are used and that staff are correctly trained in cleaning practices approved by the infection control committee.</p> <p>Findings: 1. at 1:05 PM on 11/16/11, staff member NA confirmed that a contracted housekeeping agency provides services at the off site location where radiology services are performed 2. at 10:30 AM on 11/17/11, interview with staff members NA and NG</p>	S0596	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A plan was developed on 11/30/2011. Offsite interdisciplinary rounds were conducted and all offsite cleaning products were reviewed. Revisions to the offsite cleaning products and related policies and procedures were discussed at the December Infection Control Committee (Clinical Committee). Final revisions and approval will be obtained. B. How are you going to prevent the deficiency from recurring in the future? Offsite locations were added to the interdisciplinary rounds schedule. Biannual interdisciplinary environmental rounds will occur at the offsite</p>	12/17/2011			

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	<p>indicated:</p> <p>a. the environment of care committee does "walk throughs" and observes for obvious cleanliness (or lack of) at the Radiology off site location at 885 W. Connexion Way</p> <p>b. housekeeping staff that are employees of the facility are observed two times/month for appropriate PPE (personal protective equipment), appropriate mixture of disinfectant/cleaner, and appropriate kill time</p> <p>c. there is no orientation, observation, or other monitoring being done for the contracted housekeeping staff at the off site location</p>		<p>location to ensure that all products are hospital-approved and are used correctly. Housekeeping staff is monitored during periodic environmental rounds. Non-compliance will be forwarded to the unit manager.</p> <p>C. Who is going to be responsible for steps "A" and "B" above? The Infection Preventionist in collaboration with the Housekeeping Supervisor has oversight and accountability. D. By what dates are you going to have the deficiency corrected? 12/17/2011.</p>	

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S0608	<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 policy and procedure review, observation, and staff interview, the infection control practitioner and surgery director failed to implement the policy related to removal of surgical masks after a procedure, for two staff observed (NM and NN).</p> <p>Findings: 1. at 9:00 AM on 11/16/11, review of the policy and procedure "Dress Code Perioperative" with a last revised date of 12/09, indicated: a. on page 3 under C. "Restricted Areas", item 4., reads: "Masks:...b. A new mask must be worn for each operative procedure and with respect to patient diagnosis..."</p>	S0608	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. All surgical staff is required to strictly adhere to our policy guidelines that a new mask must be worn for each operative procedure. During the survey the surveyor observed staff with the masks around their necks outside of the OR which is not prohibited per our policy. Staff is allowed to use the same mask if they are returning to the same procedure. The policy was discussed with staff and they were reminded that they must don a clean mask prior to entering each new procedure. Additional educational reminders were posted in the surgical area to serve as an ongoing reminder.</p>	12/17/2011			

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	<p>2. while on tour of the surgery department at 10:15 AM on 11/16/11, it was observed that:</p> <p>a. staff member NN was observed in the women's locker room with a surgical mask dangling about the neck</p> <p>b. staff member NN left the locker room and returned to the surgical suites area with the mask still dangling</p> <p>c. staff member NM provided the surgery department tour for no less than one hour, and wore a mask dangling about the neck through out the tour process</p> <p>3. interview with staff member NG at 10:30 AM on 11/17/11 indicated:</p> <p>a. even though the policy (listed in 1. above) does not specifically state that masks are not to be worn dangling about the neck, that is the implication in C. 4. where it states that a "new mask must be worn for each operative procedure..."</p> <p>b. staff noted to be wearing masks dangling about the neck on 11/16/11, should have disposed of their masks after exiting the surgery suite, and not wearing them about the surgery department</p>		<p>B. How are you going to prevent the deficiency from recurring in the future? Quarterly observation audits are conducted to ensure that staff is donning a clean mask prior to entering the OR for each procedure. Audits are monitored on the MOS Dashboard until compliance is sustained. The AORN standards will be reviewed and our policy will be revised as applicable. C. Who is going to be responsible for steps "A" and "B" above? The Surgical Manager in collaboration with the Infection Preventionist has oversight and accountability. D. By what dates are you going to have the deficiency corrected? December 17, 2011.</p>		

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S0610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on policy and procedure review, observation, and interview, the infection control practitioner failed to ensure the implementation of policies related to the cleaning of staff refrigerators and the storing of employee food from home in two areas (emergency department staff refrigerator, radiology staff refrigerator, and Critical Care patient refrigerator).</p>	S0610	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Emergency department, Diagnostic Imaging department, and the Critical Care Unit staff were re-educated on the personnel policy regarding unit cleaning procedures and schedules for refrigerators and freezers, on November 17, 2011.</p>	12/17/2011

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	<p>Findings:</p> <p>1. at 12:35 PM on 11/17/11, review of the policy "Cleaning and Restocking the Emergency Room", with a most recent revised date of 5/10, indicated:</p> <p>a. under section III. "Procedure Statement", it reads: "...4. Monthly Cleaning Restocking...d. When completing the monthly cleaning the following will be included: ...7. Defrosting, cleaning of refrigerators in room you are assigned..."</p> <p>2. at 12:40 PM on 11/17/11, review of the policy and procedure "Patient Food from Outside the Hospital", indicated:</p> <p>a. under "Procedure", it reads: "...4. Patient care refrigerators are solely for the use of patient food. Staff food items are NOT allowed in patient care refrigerator."</p> <p>3. at 11:30 AM on 11/15/11, while touring the ED (emergency department) staff lounge in the company of staff member ND, it was observed that the Radiology staff refrigerator/freezer and the ED staff refrigerator/freezer were both dirty with spilled, sticky substances found and crumbs and other debris noted on shelves and in/under the vegetable bins</p> <p>4. at 1:40 PM on 11/15/11, while touring the CCU (critical care unit) in the company of staff members NC and NE, it</p>		<p>B. How are you going to prevent the deficiency from recurring in the future? Unit cleaning schedules were re-enforced on December 17, 2011. Units labeled all refrigerators as "staff refrigerator", "patient nourishment", or "medication only". The periodic interdisciplinary rounds include observation of refrigerator and unit cleaning schedule/logs to ensure compliance with personal food storage and cleaning procedures. Non-compliance will be forwarded to the unit manager. C. Who is going to be responsible for steps "A" and "B" above? The Department Managers in collaboration with the Infection Preventionist have oversight and accountability. D. By what dates are you going to have the deficiency corrected? December 17, 2011.</p>				

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	<p>was observed that a staff member's (NJ) lunch bag was found in the patient refrigerator</p> <p>5. interview with staff member ND at 11:35 AM on 11/15/11 indicated a monthly cleaning schedule had not been implemented for ED since moving to the new facility</p> <p>6. interview with staff member NC at 1:45 PM on 11/15/11 indicated nurse NJ's lunch was not to have been placed in the patient's refrigerator in the CCU area</p>			

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S0788	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(9)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(9) Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be recorded.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to implement its policy related to the completion of transfer forms for 1 of 3 patients transferred from the med/surg/CCU (critical care unit) nursing unit. (pt. N7)</p> <p>Findings:</p> <p>1. at 12:40 PM on 11/17/11, review of the policy and procedure "Transferring of Patients From Hospital to Another Facility", with a most recent review date of 5/11, indicated:</p> <p>a. on page 2, in number 7., it reads: "A transfer form is to be completed..."</p> <p>2. at 10:15 AM on 11/17/11, review of the closed patient transfer records (transfers from the med/surg/CCU nursing units) indicated:</p> <p>a. pt. N7, admitted 11/7/11 and</p>	S0788	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Medical Surgical/CCU unit staff were re-educated on 12/7/2011 and 12/8/2011 regarding the policy and procedure for transferring patients from our hospital to another facility and adherence to documentation guidelines. B. How are you going to prevent the deficiency from recurring in the future? Monthly audits are performed on patients who are transferred to ensure compliance with accurately completing the transfer form. Audits will be monitored on the MOS dashboard until compliance is sustained. C. Who is going to be responsible for steps "A" and "B" above? The Medical Surgical/CCU Manager has oversight and accountability. D. By what dates</p>	12/12/2011			

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	<p>transferred 11/9/11, was lacking:</p> <p>I. the time the accepting physician was notified of the transfer (on page one of the transfer form)</p> <p>II. notation by the transferring physician of potential risks of transfer and the physician's signature (both on page 2 of the transfer from)</p> <p>3. interview with staff member NK at 12:00 PM on 11/17/11 indicated agreement that the transfer form was incomplete as stated in 2. above</p>		<p>are you going to have the deficiency corrected? 12/12/2011.</p>	

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S0872	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(P)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on review of medical staff rules and regulations, patient medical record review, and staff interview, the medical staff failed to implement the rules and regulations related to final diagnosis/discharge summary for 1 of 3 transfer patient medical records (pt. N9).</p> <p>Findings:</p> <p>1. at 12:50 PM on 11/15/11, review of the medical staff rules and regulations, with a most recent revised date of February 2011, indicated:</p> <p>a. on page 8 in Article IV: "The Medical Record", Section 2. "Responsibilities": element "O. Medical Records will be completed within 30 days of discharge visit."</p> <p>2. at 10:15 AM on 11/17/11, review of closed patient medical records indicated:</p>	S0872	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The medical staff was reminded of the bylaws and medical staff rules and regulations regarding discharge summary completion within 30 days following patient discharge on December 5, 2011 at the Medical Staff Quality Meeting and December 21, 2011 at the Medical Staff Clinical Committee Meeting. Additional reminder notices were placed in physician mailboxes and a notice will be placed in the next physician newsletter. B. How are you going to prevent the deficiency from recurring in the future? On an ongoing basis, physicians are notified when a discharge summary is greater than 21 days. Medical Record Delinquency rates, issues, and</p>	12/05/2011			

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	<p>a. pt. N9 was admitted on 8/15/11 and transferred to another acute care facility on 9/11/11 and was lacking a discharge summary in the medical record</p> <p>3. interview with staff member NK at 12:00 PM on 11/17/11 indicated the patient medical record for N9 is lacking a discharge summary and is a delinquent record</p> <p>4. interview with staff member NL at 2:45 PM on 11/17/11 indicated a patient discharge/transfer on 9/11/11 should have had a discharge summary dictated by now (11/17/11) and is a delinquent chart</p>		<p>trends are reviewed on a monthly basis at Medical Executive Committee. C. Who is going to be responsible for steps "A" and "B" above? Physician education was provided by Quality Management. Health Information Services, Medical Staff Service, and the Cheif Medical Director have direct oversight and accountability. D. By what dates are you going to have the deficiency corrected? December 5, 2011.</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 policy and procedure review, observation, and interview, the chief nursing officer failed to ensure the implementation of the policy related to expired supplies in two units toured</p>	S0912	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The expired supplies were discarded immediately while</p>	12/17/2011			

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	<p>(pre/post op area and emergency department).</p> <p>Findings:</p> <p>1. at 12:35 PM on 11/17/11, review of the policy "Cleaning and Restocking the Emergency Room", with a most recent revised date of 5/10, indicated:</p> <p>a. under item II. "Purpose Statement", it reads: "...4. To ensure use of supplies, and medications that have not expired."</p> <p>b. under item III. "Procedure Statement", it reads: "...4. Monthly Cleaning and Restocking...d. When completing the monthly cleaning the following will be included:...2. Checking all supplies,...for expiration dates, removing and replacing as necessary."</p> <p>2. at 10:35 AM on 11/15/11, while on tour of the ED (emergency department), in the company of staff member ND, it was observed in the Trauma room:</p> <p>a. in a respiratory bag hanging on the crash cart, a tape across the top indicated the Res Q Pod inside would expire 10/31/11--upon opening the bag, the Res Q Pod was still inside (with a 10/31/11 exp. date)</p> <p>b. in the cabinets were 2 Arrow brand Percutaneous Sheath Introducer kits that expired 8/11</p> <p>3. at 1330 on 11/15/11, while on tour of</p>		<p>the surveyor was on site. The cleaning and rotation of supplies procedures were updated on December 1, 2011. The Surgical Department and the Emergency Department staff were re-educated on 12/6/2011 and 12/7/2011 to strictly adhere to our policy regarding cleaning and stocking supplies, which includes checking all supplies for expiration dates.</p> <p>B. How are you going to prevent the deficiency from recurring in the future? Staff are assigned to monitor a specific area of the unit and document findings in the log book. Verification of completion will be monitored by the shift supervisor. The Department Managers are performing quarterly audits to ensure compliance with rotating supplies to remove supplies before expiration. Audits will be monitored on the MOS Dashboard until compliance is sustained.</p> <p>C. Who is going to be responsible for steps "A" and "B" above? The Department Managers along with the VP of Clinical Services has oversight and accountability of this process.</p> <p>D. By what dates are you going to have the deficiency corrected? December 17, 2011.</p>				

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	<p>the pre/post op area, in the company of staff members A2, A6, A16 and A17, it was observed in a respiratory bag hanging on the crash cart, a tape across the top indicated the Res Q Pod inside would expire 10/31/11--upon opening the bag, the Res Q Pod was still inside (with a 10/31/11 exp. date)</p> <p>4. interview with staff members ND, A2, A6, A16 and A17 during the survey process, indicated the nursing staff should have replaced the expired supplies in both nursing areas stated in 2. and 3. above, and replaced them with non-expired products</p>			

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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 "Blood and Blood Component Administration" policy and procedure, patient blood transfusion records, and staff interview, the hospital failed to ensure blood transfusions were administered in accordance with approved medical staff policies and procedures for 11 of 12 blood transfusions reviewed.</p> <p>Findings included:</p> <p>1. On 11-15-11 between 3:30 PM and 4:30 PM, review of "Blood and Blood Component Administration" policy / procedure, approved on "12/30/09" read: "...Verify the prescribing practitioner's written order for blood...required for administration of any blood components..." and "...Obtain assessment and vital signs 15 minutes after start of transfusion. Continue to...obtain vital signs hourly until transfusion is</p>	S0952	<p>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Parkview Whitley Hospital gave the surveyor the extended text Blood and Blood Component Administration Policy and Procedure. This policy stated under #22 to take vital signs 15 minutes after start of transfusion and to obtain vital signs hourly until transfusion is completed. Our quick sheet reference sheet (#22) states to obtain vital signs 15 minutes after start of transfusion and to obtain hourly vital signs only for pediatric patients until transfusion is completed. Our transfusion administration record (TAR) directs vital signs to be done pre transfusion, within fifteen minutes of the transfusion and immediately post transfusion. This is directed in the flow, as well as the written instructions on the form. Our netlearning (on line</p>	12/14/2011			

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	<p>completed..."and "...Obtain post transfusion vital signs..."</p> <p>2. Review of patient records on 11-16-11 between 2:00 PM and 3:30 PM revealed the following:</p> <p>a. Patient #L1 received a transfusion of leukoreduced packed red blood cells (LRBC) on 9-30-11. The transfusion was started at "0915" and ended at "1120". Hourly vital signs were not documented, as required by approved policy / procedure.</p> <p>b. Patient #L2 received a transfusion of LRBC on 9-7-11. The transfusion was started at "1215" and ended at "1610" The time fifteen minute and post transfusion vital signs were performed was not documented and it was unable to be determined if those vital signs were performed in accordance with approved policy / procedure. Hourly vital signs were not documented, as required by approved policy / procedure.</p> <p>c. Patient #L3 received a transfusion of LRBC on 9-3-11. The transfusion was started at "0900" and ended at "1045". The time pre-transfusion vital signs were performed was not documented and it was unable to be determined if those vital signs were performed in accordance with approved policy / procedure. Hourly vital signs were not documented, as required by approved policy / procedure.</p>		<p>education) for RNs also directs RNs on the taking of vital signs as listed in the quick sheet reference and on our TAR. Our reference for blood transfusion administration also states to take vital signs fifteen minutes after start and immediately post transfusion. Our Extended Text version on Blood and Blood Components Administration was in error in directing RNs to take vital signs hourly (except for pediatric patients). The extended text version was reviewed by the Blood Transfusion Committee and the error was corrected and the policy was approved on 12/14/2011.</p> <p>B. How are you going to prevent the deficiency from recurring in the future? The policy regarding frequency of vital signs during transfusions was corrected to reflect our current practice. Monthly audits are performed to ensure that vital signs are completed as outlined in the policy.</p> <p>C. Who is going to be responsible for steps "A" and "B" above? Nursing Department Managers along with the VP of Clinical Services has oversight and accountability of this process.</p> <p>D. By what dates are you going to have the deficiency corrected? 12/14/2011.</p>				

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	<p>d. Patient #L4 received two transfusions of LRBC on 8-9-11 and on 9-30-11. The first transfusion (8-9-11) was started at "1953" and ended at "2025". Hourly vital signs were not documented, as required by approved policy / procedure. The order for the second transfusion (9-30-11) read: "Type and Crossmatch...When? 9-30-11...For (Type of blood product)..Red Blood Cells...#Units 2..." An order to give the crossmatched red blood cells was not documented. One unit was started at "1327" on 9-30-11, and ended at "1515". The time post-transfusion vital signs were performed was not documented and it was unable to be determined if those vital signs were performed in accordance with approved policy / procedure. Hourly vital signs were not documented, as required by approved policy / procedure.</p> <p>e. Patient #L5 received two transfusions of LRBC on 8-2-11 and 9-1-11. The first transfusion (8-2-11) was started at "1315" and ended at "1525". Hourly vital signs were not documented, as required by approved policy / procedure. The second transfusion (9-1-11) was started at "0750" and ended at "0945". The time pre-transfusion and fifteen minute vitals signs were performed was not documented and it was unable to be determined if those vital signs were performed in accordance with approved</p>			

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	<p>policy / procedure. Hourly vital signs were not documented, as required by approved policy / procedure.</p> <p>f. Patient #L6 received a transfusion of LRBC on 8-12-11. The order read: "Type + X. Match for 2 units of packed RBC's". An order to give the crossmatched red blood cells was not documented. One transfusion was started at "1346" and ended at "1645". Pre-transfusion vital signs were performed at "1300", 45 minutes before the transfusion was started, not within 30 minutes as required by approved policy / procedure. Hourly vital signs were not documented, as required by approved policy / procedure.</p> <p>g. Patient #L7 received a transfusion of LRBC on 8-29-11. The transfusion was started at "1020" and ended at "1155". Fifteen minute vital signs were performed at "1030", 10 minutes after the transfusion was started. Hourly vital signs were not documented, as required by approved policy / procedure.</p> <p>h. Patient #L8 received a transfusion of LRBC on 8-30-11. The transfusion was started at "1110" and ended at "1255". The time post-transfusion vital signs were performed was not documented and it was unable to be determined if those vitals signs were performed in accordance with policy / procedure. Hourly vital signs were not</p>			

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	<p>documented, as required by approved policy / procedure.</p> <p>i. Patient #L9 received a transfusion of LRBC on 4-18-11. The transfusion was started at "1750" and ended at "2025". Hourly vitals signs were not documented, as required by approved policy / procedure.</p> <p>3. In interview on 11-16-11 between 2:00 PM and 4:30 PM, Staff Member #L23 acknowledged the above findings.</p>			

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S1038	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(3)(4)(5)(6)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(3) Review the use of medications with the standards developed by the medical staff, which include stop orders for scheduled drugs and biologicals not specifically prescribed as to time or number of doses.</p> <p>(4) Allow for adequate drug therapy monitoring procedures to exist.</p> <p>(5) Minimize medication errors and document, monitor, evaluate, and report adverse drug reactions and medication errors.</p> <p>(6) Provide for the maintenance of drug and poison information materials.</p> <p>Based on document review and interview, the facility lacked the policy/procedure requirement for documenting adverse drug reactions in the patient record.</p> <p>Findings:</p> <p>1. The policy/procedure Adverse Drug Event Reporting lacked a provision for any documentation in the patient record when an adverse drug event is identified and for notification of the responsible physician.</p> <p>2. During an interview on 11-16-11 at</p>	S1038	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The hospital has a policy/procedure that requires licensed professional staff to immediately report medication errors and drug reactions to the ordering medical staff member. The policy/procedure also requires that an entry of the medication given and/or the drug response be recorded. In addition, an event report is also required to be completed. (Copy attached.)</p> <p>B. How are you</p>	11/17/2011

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	1550 hours, employee #A2 confirmed that the policy/procedures lacked the requirement for documenting the medication administered or signs and symptoms of an adverse drug event in the patient record and notifying the responsible physician of the adverse drug event.		<p>going to prevent the deficiency from recurring in the future? Licensed professional staff to continue to immediately notify the ordering physician of a medication error and drug reaction and document this in the patient record. On an ongoing basis, nurse managers review all medication errors and drug events and utilize the nursing peer review process when necessary to identify and correct discrepancies. C. Who is going to be responsible for steps "A" and "B" above? VP of Clinical Service has oversight and accountability. D. By what dates are you going to have the deficiency corrected? 11/17/2011.</p> <p>Addendum 4/8/2012 The Parkview Whitley Hospital Policy titled Safe Administration of Drugs (last updated 6/2009) requires that medication errors and drug reactions shall be reported immediately to the practitioner who ordered the drug and that an entry of the medication given and or the drug response shall be properly recorded. Furthermore, the Parkview Whitley Hospital Policy & Procedure titled Medication Variance (Mosby's Nursing Skills) updated 7/2009 also requires upon discovery of a medication error that accurate information regarding the medication must be recorded in the patient record and that the</p>		

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			attending physician should be notified of the error immediately. The person involved with or discovered the variance must complete an Event Report describing the variance.	

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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 document review, observation and interview, the facility failed to safely store and maintain 2 compressed oxygen cylinders which resulted in a hazard to patients and employees of the facility. Findings:</p> <p>1. Review of the Occupational Safety and Health Administration (OSHA) general requirements for compressed gasses in 29 Code of Federal Regulations (CFR) 1910.101 indicated the following: Per 29 CFR 1910.101(b), the in-plant handling, storage and utilization of all compressed gas cylinders must be in accordance with Compressed Gas Association (CGA) Pamphlet P-1 Safe Handling of Compressed Gas Cylinders. " Gas cylinders should be properly secured at all times to prevent tipping, falling, or</p>	S1118	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The oxygen cylinders were secured immediately by chains during the survey process. B. How are you going to prevent the deficiency from recurring in the future? Staff were re-educated on our policy on 11/16/2011 regarding the need to strictly adhere to securing the oxygen cylinders with a chain. Securing of the oxygen cylinders are evaluated during Facilities/Security daily rounds to ensure compliance. Non-compliance will be forwarded to unit managers. C. Who is going to be responsible for steps "A" and "B" above? The Facilities Manager has oversight and accountability of this process. D. By what dates are</p>	11/17/2011			

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	<p>rolling. They can be secured with straps or chains connected to a wall bracket or other fixed surface, or by use of a cylinder stand. "</p> <p>2. During a tour on 11-15-11 at 1520 hours, the following hazardous condition was observed in the liquid oxygen storage compound; 2 large compressed oxygen gas cylinders were standing upright and not secured by a chain immediately available and connected to a bracket behind the cylinders.</p> <p>3. During an interview on 11-15-11 at 1520 hours, staff #A6 confirmed that the compressed gas cylinders should be secured at all times with the safety chain.</p>		<p>you going to have the deficiency corrected? 11/17/2011.</p>	

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</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>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation and interview, the facility failed to perform equipment maintenance ensuring a safe working environment for employees in one department.</p> <p>Findings:</p> <p>1. On 11-16-11 at 1100 hours, staff #A6 was requested to provide documentation of preventive maintenance (pm) for a facility floor scrubber and none was provided prior to exit.</p> <p>2. During a tour of the environmental services department on 10-16-11 at 1450 hours, a Hawk 175 rpm floor buffer and a Tennant 175 rpm floor buffer was observed without evidence of recent</p>	S1164	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The deficiency was corrected while the surveyor was on site and evidence of completion was provided to the surveyor. Preventive maintenance was completed on 11/16/2011 for both buffers with no deficiencies found. B. How are you going to prevent the deficiency from recurring in the future? Both buffers have had annual inspections performed. In addition, the housekeeping department was provided a list with all housekeeping equipment with the date that the preventive maintenance was completed and the next scheduled date for preventive maintenance. C. Who is going to be responsible for steps "A" and "B" above? The Housekeeping Manager has oversight and is accountable for</p>	11/17/2011

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	<p>inspection and testing.</p> <p>3. During an interview on 10-16-11 at 1450 hours, staff #A11 confirmed that the floor scrubbers failed to indicate that they had received any recent preventive maintenance.</p>		<p>this process. D. By what dates are you going to have the deficiency corrected? 11/17/2011.</p>	

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the facility failed to follow its policy/procedure and perform defibrillator inspection and testing as recommended by the manufacturer.</p> <p>Findings:</p> <p>1. The policy/procedure Cleaning and restocking the Medical-Surgical Department (reviewed 05-11) indicated the following: Nurses Only ...Crash cart check every shift. [and] The RN will check the defibrillators, performing a test defibrillation as well as a test pacing as per manufacturer recommendation.</p> <p>2. Facility documentation titled "Parkview Health Defibrillator & Code Cart Checklist" and dated November 2011 for the Medical Surgical area lacked documentation of checks for the following shifts and dates:</p> <p>a) Night Shift - no documentation on</p>	S1168	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Staff were re-educated on the policy regarding defibrillator and code cart checklist on 11/16/2011, 12/7/2011, and 12/8/2011 and instructed to strictly adhere to the policy guidelines on documentation. B. How are you going to prevent the deficiency from recurring in the future? The nurse assignment sheet has been updated to include checking the crash cart every shift. The manager is auditing weekly to ensure that the checks are completed. Audits will be monitored on the MOS dashboard until compliance is sustained. C. Who is going to be responsible for steps "A" and "B" above? The Medical/Surgical/CCU Manager has oversight and is accountable for this process. D. By what dates are you going to have the</p>	11/24/2011	

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	<p>11-03, 11-04 or 11-05-11.</p> <p>b) Day Shift - no documentation on 11-03, 11-04, 11-05, 11-06, 11-08, 11-10, 11-11, 11-12, or 11-13-11.</p> <p>c) Evening Shift - no documentation on 11-02, 11-03, or 11-05-11.</p> <p>3. Facility documentation titled "Parkview Health Defibrillator & Code Cart Checklist" and dated November 2011 for the Constant Care area lacked documentation of checks for the following shifts and dates:</p> <p>a) Night Shift - no documentation on 11-04, 11-05, 11-06, or 11-11-11.</p> <p>b) Day Shift - no documentation on 11-05, 11-06, 11-12, or 11-13-11.</p> <p>c) Evening Shift - no documentation on 11-05, 11-12 or 11-13-11.</p> <p>4. During an interview on 11-15-11 at 1330 hours, staff #A3 confirmed that the required shift Checklists had not been maintained by staff.</p> <p>5. The Phillips Model M4735A Defibrillator Operators Manual, page 11-6 indicated the following: Perform each of these checks and record the results. The guidelines for completing the checks are as follows: Defibrillator Inspection - make sure the</p>		<p>deficiency corrected? 11/24/2011</p>	

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	<p>HeartStart XL is clean, clear of objects on top and has no visible signs of damage.</p> <p>Paddles/Cables/Connectors - make sure there are no cracks, broken wires, or other visible signs of damage. Make sure the connectors engage securely.</p> <p>Audio - verify there is an audible tone when the HeartStart XL is turned on.</p> <p>Printer - make sure the printer: has sufficient paper ... and prints properly.</p> <p>6. Review of the Parkview Health Defibrillator & Code Cart Checklist failed to incorporate the manufacturer recommended checks listed above or identify a reference page located with the checklist documentation that included the recommendations.</p> <p>7. During an interview on 11-16-11 at 1215 hours, staff #A8 confirmed that the Checklists failed to incorporate or include by reference the manufacturer recommendations for equipment checks.</p> <p>8. The policy/procedure Crash Cart/Defibrillator/AED Checks (reviewed 06-09) indicated the following: In areas that provide 24-hour patient care the</p>			

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	<p>check must be performed each calendar day. The policy/procedure failed to follow the manufacturer recommendations for the Phillips HeartStart XL Defibrillator, page 11-3 that indicated the following: Perform a "Shift/System Check" every shift to verify that the HeartStart XL is functioning properly....</p> <p>9. The policy/procedure Crash Cart/Defibrillator/AED Checks (reviewed 06-09) indicated the following: AED's checked for the following: a) Status indicator is lit [and] b) AED is locked with breakaway lock.</p> <p>10. Facility documentation titled "Parkview Health AED Checklist" and dated November 2011 for the Infusion Clinic/Outpatient Services area lacked the following documentation: no check was performed by staff on 11-03-11 and no documentation from 11-01 through 11-15 confirmed that the Status Indicator was observed by staff to indicate the AED was ready to use.</p> <p>11. During an interview on 11-16-11 at 1215 hours, staff #A8 confirmed that the Checklists failed to indicate staff</p>			

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	confirmation that the AED was ready for use.			

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NAME OF PROVIDER OR SUPPLIER PARKVIEW WHITLEY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1260 E SR 205 COLUMBIA CITY, IN 46725		
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S1234	<p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(d)(1)</p> <p>(d) A full-time, part-time, or consulting radiologist or physician qualified by education and experience in the service provided as determined by the medical staff shall do the following:</p> <p>(1) Supervise the service provided.</p> <p>Based on document review and interview, the medical staff failed to appoint a radiologist or physician qualified by education and experience to supervise the radiology services and failed to ensure that a qualified practitioner adequately supervised the service.</p> <p>Findings:</p> <p>1. On 11-15-11 at 0930 hours, staff #A2 was requested to provide documentation indicating that the radiology services medical director was appointed by the medical staff and none was received prior to exit.</p> <p>2. Review of the Radiation Safety Committee meeting minutes for 2011 failed to indicate participation or involvement by the radiology services medical director for the facility.</p> <p>3. On 11-16-11 at 1020 hours, staff #A15</p>	S1234	<p>A. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Per medical staff bylaws, the Medical Staff President appoints the Radiology Services Medical Director/Radiology Clinical Advisor which was completed on 12/2010 for 2011. The Manager of Radiology and the Radiology Clinical Advisor were informed that attendance at the Radiation Safety Committee Meeting is an expectation. The Radiology Clinical Advisor will review and approve Radiology Services policies and procedures that require medical staff approval.</p> <p>B. How are you going to prevent the deficiency from recurring in the future? On an ongoing basis, the Radiology Manager will notify the Radiology Clinical Advisor of policies that require review and approval of the Advisor. C. Who is going to be responsible for steps "A" and "B" above? The Diagnostic</p>	12/17/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150101	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/17/2011
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	<p>was requested to provide documentation indicating that the radiology medical director had reviewed and approved the radiology department policy/procedures and none was received prior to exit.</p> <p>4. On 11-16-11 at 1020 hours, staff #A15 confirmed that the radiology services medical director had not reviewed and approved the policy/procedures for the department.</p>		<p>Imaging Manager and the Radiology Clinical Advisor have oversight and are accountable. D. By what dates are you going to have the deficiency corrected? 12/17/2011.</p>	