

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151312	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2012
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 720 SOUTH SIXTH ST MONTICELLO, IN 47960
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 12/11/2012 through 12/12/2012</p> <p>Facility Number: 005034</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 12/18/12</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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S000102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on document review and interview, the facility failed to comply with all applicable state laws for 1 (#19) of 1 unlicensed nursing aide employee files reviewed.</p> <p>Findings include:</p> <p>1. IC 16-28-13-4: a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of IU Health White Memorial Hospital policy 3.34</p>	S000102	<p>The Human Resource Director will begin on march 13, 2013 to verify in the Nurse AideVerification Directory all nursing assistants prior to the employee beginning work. The Human Resource Director will retain the print out from the Nurse Aide Verification Directory in the employee's file. The Human Resource Director will do periodic employee file checks to review this standard is being met going forward from March 13, 2013.</p>	03/13/2013

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	<p>indicated reference to verification of certifications of Certified Nurse Aides through the Certified Nurse Aide/Home Health Registry. The policy does not indicate that uncertified nurse aides are checked through the nurse aide registry.</p> <p>3. Review of #19's employee file indicated that he/she was hired on September, 2009 as a Nurse Aide and employee #19's file lacked documentation of a nurse aide registry report.</p> <p>4. At 1:05 PM on 12/12/2012, staff member #18 confirmed that staff member #19's Human Resource file did not evidence a nurse aide registry check. Staff member #18 indicated the hospital did not perform nurse aide registry checks on any of their unlicensed nurse aides.</p>				

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure two (2) services were part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <p>1. IU Health White Memorial Hospital Quality and Patient Safety 2012 Annual Plan implements all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p>	S000406	<p>Audiology &amp; Linen Services data will be reflected in Quality Management December 28, 2012 meeting minutes. Audiology and Linen Services data will be presented to QM on a quarterly basis and will be reflected in meeting minutes, include Audiology &amp; Linen Services to 2013 Quality Plan, and review meeting minutes to ensure data captured in meeting. Quality Management Coordinator</p>	12/28/2012	

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	<p>2. Review of the facility's QA&amp;I program indicated it did not include Laundry and Audiology services.</p> <p>3. At 1:51 PM on 12/12/2012, staff member #3 confirmed Laundry and Audiology services were not going through the facility's QA&amp;I process.</p>				

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, document review, and staff interview, the facility failed to ensure hospital staff that were working in the Laboratory Department were wearing their lab coat per policy and procedures and failed to ensure a safe, sanitary environment by checking for cleanliness and outdated supplies in the Obstetrical, Surgery, and Emergency Departments.</p> <p>Findings included:</p> <p>1. Infection Control policy #45.02.00 last reviewed October 2010, states, "Impervious gowns must be worn during procedures that are likely to generate splashes or sprays of blood, secretions or excretions or cause soiling of clothing. Impervious Lab Coats</p>	S000554	<p>1, 2, 3) The lab technician was verbally counseled on the date of the occurrence (December 11, 2012) by the Assistant Director of Laboratory Services as to the requirement of an impervious lab coat when working in this area, even if at a microscope station. Subsequent follow up counseling was verbally made by the Director of Laboratory Services on December 20, 2012. The lab technician has been made aware of the potential consequences of not adhering to this policy and that further disciplinary actions may be necessary if there is not strict compliance. Also, the Director of Laboratory Services provided education to all laboratory staff on December 21, 2012 which included a full review of the Infection Control Standard Precautions Policy #45.02.00 which includes the requirements for wearing of impervious lab coats. Laboratory management will perform regular walkthroughs of the department for the next six months to monitor for compliance with this requirement. Any</p>	01/13/2013			

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	<p>will be used in Lab and Cardio workrooms."</p> <p>2. At 12:35 PM on 12/11/2012, the Laboratory Department was toured. One Lab Technician in the Laboratory was observed sitting at a workstation looking through a microscope also located at the work area. This staff member was not wearing a lab coat while working in the Laboratory.</p> <p>3. At 12:40 PM on 12/11/2012, staff member #2 confirmed that there was a Lab Technician working in the Laboratory Department without wearing his/her lab coat.</p>		<p>violations will be handled in accordance with all applicable hospital policies.</p> <p>1, 2) Cidex strips are not used in the OB unit; the strips were discarded at the time of the survey, 12/11/12. Effective immediately, OB and Environmental staff when cleaning and stocking will ensure only approved cleaning supplies are available. Director of Inpatient Services will make random checks to ensure only approved cleaning supplies are in the OB department.</p> <p>3) Deficiency of dust on suction canisters was corrected the same day of the survey, 12/11/12 by the SDS staff and ES staff in the patient care rooms in SDS. The OR staff was instructed to start including the cleaning of suction canisters and lids as part of the daily cleaning process in SDS. Directed to the OR staff that as a process of the daily room cleaning by OR, we will make sure the suction canisters are cleaned with the approved hospital disinfectant if the suction is not used. The Director of Surgery will make random rounds to check the equipment in the SDS rooms to make sure it is clean and rid of dust.</p> <p>4) OR staff in SDS will be responsible to clean the suction canisters in the room after patients are dismissed. It was directed to the OR staff</p>		

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			<p>that as a process of daily room cleaning by OR, we will make sure the canisters are cleaned with the approved hospital disinfectant if the suction is not used.</p> <p>The Director of Surgery will make random rounds to check the equipment in the SDS rooms to make sure it is clean and rid of dust.</p> <p>5) The BD spinal tray in the OR med room area was removed immediately from the cabinet at the time of the survey 12/12/12 and a new tray with a good expiration date was replaced in the cabinet that day by the OR staff.</p> <p>A surgery supply expiration checklist will be completed every 3 months by assigned members of the surgery staff for all rooms and cabinets in the department. Those staff will be responsible for the checking of supplies at the beginning of that month. If a product expires before the next check, the item will be removed and replaced with a later expiration date. If a supply cannot be replaced with a later date, it will be documented in the expiration logbook located in PACU, which contains a monthly list of expiration dates. Staff informed of the new checklist during the 12/26/12 staff meeting. The new checklist of room expiration dates will be completed by 1/10/13.</p> <p>Assigned OR staff are</p>		

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			<p>responsible for the initial checks, but the Director of Surgery will be responsible to make sure checks are completed as assigned to staff. The Director will be responsible to check the logbook for monthly expirations.</p> <p>6) The 2 Medtronic pediatric defibrillator pads were removed from the crash cart immediately during the survey on 12/11/12. A staff member was given the pads to dispose of and new pads were obtained by staff and placed on the cart that day.</p> <p>Supplies are to be checked for expiration dates and any expired item will be documented on a tag with the product, date of expiration, and location and placed on the outside of the crash cart. The supply expiration dates will be reviewed with each daily check and the expired supplies replaced when indicated and all supplies will be rechecked after each use of the crash cart. Staff will be re-educated on the current crash cart policy and the tag for expiration date of supplies by January 10, 2013.</p> <p>The Director of Surgery will make random checks to be sure the supply expiration tag does not contain expired dates for supplies. The crash cart expiration date completion will be reported at department staff meetings on a quarterly basis.</p> <p>7) Staff member was referring to the checks daily for the monitor and locks when we are here</p>	

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			<p>Monday-Friday, excluding holidays, not the supplies. The crash cart is checked daily for numbered lock tags on the cart, broselow bag, and pediatric drug box, and the proper functioning of the monitor/defibrillator and suction. Weekly joule testing will be once a week.</p> <p>The crash cart supplies are to be checked for expiration dates. Any expired item will be documented on a tag with the product, date of expiration, and location and placed on the outside of the crash cart. The supply expiration dates will be reviewed with each daily check and the expired supplies replaced when indicated or all supplies will be rechecked after each use of the crash cart. Staff will be re-educated on the current crash cart policy and the tag for expiration date of supplies by January 10, 2013.</p> <p>The Director of Surgery will make random checks to be sure the crash cart is checked daily and the supply expiration tag does not contain expired dates for supplies. The crash cart and expiration date completion will be reported at department staff meetings on a quarterly basis.</p> <p>8A) The supplies found were changed on out on 12/12/12 (date found).</p> <p>Every 6 month crash cart checks will be assigned to individual technicians and they will be given a copy of the supply sheet that</p>		

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			<p>lists all respiratory supplies in the crash cart. It will be their responsibility to check each supply on that list for package integrity issues and expiration dates. They will be instructed to list the expiration dates on the supply sheet and pull any supplies that will expire prior to the next scheduled crash cart check. They will then highlight on the supply sheet the next upcoming supply to expire.</p> <p>Cardiopulmonary RCP's will be accountable with Director oversight.</p> <p>8B) The supplies found were changed on out on 12/12/12 (date found).</p> <p>Every 6 month crash cart checks will be assigned to individual technicians and they will be given a copy of the supply sheet that list all respiratory supplies in the crash cart. It will be their responsibility to check each supply on that list for package integrity issues and expiration dates. They will be instructed to list the expiration dates on the supply sheet and pull any supplies that will expire prior to the next scheduled crash cart check. They will then highlight on the supply sheet the next upcoming supply to expire.</p> <p>Cardiopulmonary RCP's will be accountable with Director oversight.</p>		

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			<p>8C) Item was removed from box immediately. Povidone swabs will no longer be kept in the pediatric supply box. Swabs will be obtained from the supply room where stock rotates more frequently and is checked for outdates monthly. All rooms in the emergency department will be checked for outdates monthly. The swabs in the supply rooms are used and rotated more frequently than in the pediatric box. The pediatric box will have a tag on the outside of the box with the next supply to be outdated and will be checked monthly to ensure compliance. Director of Emergency Services will be responsible for monitoring compliance and reporting monthly at department staff meetings. On the date of survey, the povidone swab was removed from the pediatric box. The ED Outdate/Expiration schedule will be in effect by January 10, 2013.</p> <p>8D) Item was removed from box immediately. Spinal needles will no longer be kept in the pediatric supply box. Spinal needles will be obtained from the supply room where stock rotates more frequently and is checked for outdates monthly. All rooms in the emergency department will be checked for outdates monthly. The spinal needles in the supply room are used and rotated more frequently than in the pediatric box. The pediatric box will have a tag on</p>	

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			<p>the outside of the box with the next supply to be outdated and will be checked monthly to ensure compliance.</p> <p>The Director of Emergency Services will be responsible for monitoring compliance and reported monthly at department staff meetings.</p> <p>On the date of survey, the spinal needle was removed from the pediatric box. The ED Outdate/Expiration schedule will be in effect by January 10, 2013.</p> <p>8E) The supplies found were changed on out on 12/12/12 (date found).</p> <p>Every 6 month crash cart checks will be assigned to individual technicians and they will be given a copy of the supply sheet that lists all respiratory supplies in the crash cart. It will be their responsibility to check each supply on that list for package integrity issues and expiration dates. They will be instructed to list the expiration dates on the supply sheet and pull any supplies that will expire prior to the next scheduled crash cart check. They will then highlight on the supply sheet the next upcoming supply to expire.</p> <p>Cardiopulmonary RCP's will be accountable with Director oversight.</p> <p>8F) The supplies found were changed on out on 12/12/12 (date found).</p> <p>Every 6 month crash cart checks</p>	

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			<p>will be assigned to individual technicians and they will be given a copy of the supply sheet that lists all respiratory supplies in the crash cart. It will be their responsibility to check each supply on that list for package integrity issues and expiration dates. They will be instructed to list the expiration dates on the supply sheet and pull any supplies that will expire prior to the next scheduled crash cart check. They will then highlight on the supply sheet the next upcoming supply to expire.</p> <p>Cardiopulmonary RCP's will be accountable with Director oversight.</p> <p>9) The log on the crash care indicated the cart had just been checked and restocked on 12/10/12. Staff member #A16 indicated the emergency carts were changed out every 6 months and all of the supplies should be checked for outdates at that time. All staff will be re-educated on our current crash cart policy. Our crash cart policy states: 1. Document the first date of expiration, whether a medication or supply item (Foley catheter tray, NS irrigation solution), on a tag outside the crash cart, Broselow Bag, and Emergency Drug boxes. 2. Exchange the drug/item prior to the expiration date. And 3. At the time of exchange, recheck all other expiration dates prior to attaching</p>		

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	<p>1. During the tour of the Obstetrical Department at 1:50 PM on 12/11/12, accompanied by staff members #A10 and A13, an open container of Cidex OPA test strips, with a manufacturer's expiration date of 09/2011, was observed on a shelf in the soiled room.</p> <p>2. Both staff members indicated the Cidex OPA solution was not used on the unit and they did not know why the strips were in the room.</p>		<p>a new numbered lock. All rooms in the emergency department will be checked for outdated monthly The schedule includes checking all tags on crash carts and emergency drug boxes. The crash cart will have a tag on the outside of the cart with the next supply to be outdated and will be checked monthly to ensure compliance. Education of staff and enforcement of policy will be in effect by January 10, 2013. The Director of Emergency Services will be responsible for monitoring compliance and report quarterly at department staff meetings.</p>		

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	<p>3. During the tour of the Same Day Surgery area at 2:25 PM on 12/11/12, accompanied by staff members #A10 and A12, a layer of dust was observed on the wall mounted suction canisters in the patient bay areas.</p> <p>4. Staff member #A12 indicated the nursing staff cleaned most of the items in the areas, but environmental services would be responsible for the wall and floor areas.</p> <p>5. During the tour of the Surgical Department at 2:40 PM on 12/11/12, accompanied by staff member #A12, one of one BD Spinal Anesthesia Tray, with a manufacturer's expiration date of 09/2012, was observed in a cabinet of the medication room.</p> <p>6. During the tour of the Recovery Room at 3:00 PM on 12/11/12, accompanied by staff member #A12, two of two Medtronic Pediatric Pads, with a</p>			

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	<p>manufacturer's expiration date of 11/28/12, were observed on the top of the crash cart.</p> <p>7. Staff member #A12 indicated the cart was checked daily.</p> <p>8. During the tour of the Emergency Department at 10:40 AM on 12/12/12, accompanied by staff member #A16, the following items were observed:</p> <p>A. One of one Pediatric endotracheal introducer, with an expiration date of 09/2012, in the crash cart.</p> <p>B. One of one endotracheal tube stylet, with an expiration date of 03/2012, in the crash cart.</p> <p>C. One of one Povidone swab, with an expiration date of 02/2012, in the emergency pediatric box.</p> <p>D. One of one 22 gauge spinal needle, with an expiration date of 10/2011, in the emergency pediatric box.</p> <p>E. Two of two nasopharyngeal airways, one with an expiration date of 06/2011 and one with an</p>			

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	<p>expiration date of 07/2012, in the Broselow cart.</p> <p>F. One of one stylet, with an expiration date of 08/2011, in the Broselow cart.</p> <p>9. The log on the crash cart indicated the cart had just been checked and restocked on 12/10/12. Staff member #A16 indicated the emergency carts were changed out every 6 months and all of the supplies should be checked for outdates at that time.</p>			

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S000596	<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 observation, document review, and interview, the facility failed to ensure chemical Cidex OPA was used according to the manufacturer's recommendations and per policies for the Radiology Department.</p> <p>Findings included:</p> <p>1. Cidex OPA manufacture sheet requires: 1) The user should be adequately trained in the demonstration and disinfection of semi-critical medical devices and the handling of liquid chemical</p>	S000596	<p>1,2,3,4) After thorough review of equipment manual for recommended cleaning, Cidex has been removed from the Radiology department effective 12-27-12.</p> <p>Review a list of chemicals used throughout the hospital on a yearly basis. Infection Preventionist</p>	12/27/2012			

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	<p>germicides, 2) Once opened, the unused portion of the solution may be stored in the original container up to 75 days until used, 3) Record the date the container was opened on the container label or in a log book, record the date the solution was poured outside the original container and the product must be used within 14 days, 4) Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immerging it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done 5) Use Personal Protective Equipment (PPE) when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns, and 6) the lids for the test strips and solution need to be tight fitting.</p> <p>2. Nursing Service policy #41.03.16.01, last reviewed 3/2012, states, "Don personal protective equipment: gloves; eye protection; and fluid-resistant lab coat/apron.</p>			
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	<p>Record the date that the bottle of Cidex OPA and Test strips was opened on the container label. Repeat the rinse process twice, for a total of 3 rinses. Each rinse should use fresh/sterile water (if applicable). Instruments should be immersed in rinse water for at least 1 minute each time."</p> <p>3. A 1:15 PM on 12/11/2012, an Ultrasound room was inspected with an Ultrasound Technician. An open gallon of Cidex OPA high-level disinfectant was observed on the counter in the room. The gallon was observed with no date on it reflecting when it was first opened. Also on the counter was a container of test strips with the lid to the container open and the container was observed with no date on the container. The room was observed without the proper PPE available for the handling of Cidex OPA.</p> <p>4. At 1:20 PM on 12/11/2012, staff member #8 indicated he/she does</p>			

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	not use PPE when handling the Cidex OPA disinfectant. The staff member indicated he/she rinses the ultrasound instrument under running water from the faucet.			

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S000870	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N)</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>(N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.</p> <p>Based on policy and procedure review, medical record review, and interview, the facility failed to ensure physician orders were authenticated and transcribed according to policy in 9 of 15 closed inpatient medical records reviewed (#N6, N7, N8, N9, N10, N11, N13, N18, and N20).</p> <p>Findings included:</p> <p>1. The facility policy "Content of Patient Records", last reviewed 01/12, indicated, "Inpatient Records: ...All entries in the patient record must be dated and timed including, but not limited to progress notes and orders. ...Emergency Room Records: ...All entries in the patient record must be dated and timed including,</p>	S000870	<p>1,2) On December 21, 2012, the Medical Records Director spoke with the physicians identified in the deficiencies regarding proper authentication and entry of orders into the chart. A memo was distributed by the Medical Records Director to all medical staff regarding date &amp; time entries on December 21, 2012. On December 21, 2012, a signature key was added to the Physician's Orders Emergency Department form #1100 to bring awareness for documenting date AND time. The changes to the orders will be educated to the physicians and nursing staff by the Emergency Room Director. Information will also be presented by the Medical Records Director to all physicians at the January 9, 2013 Medical Executive</p>	01/10/2013			

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	<p>but not limited to progress notes and orders."</p> <p>2. The facility policy "Physician Orders: Verbal and Telephone", last revised 06/12, indicated, "6. All verbal and telephone orders must be signed by the prescribing practitioner within forty-eight (48) hours."</p> <p>3. The facility policy "Physician Orders: Transcription of Physicians' Orders &amp; Routines 'Chart Checks' for Inpatients", last revised 06/12, indicated, "Each set of orders written by the physician must be verified, also known as being 'signed off' or 'noted', by an RN [Registered Nurse] or an LPN [Licensed Practical Nurse]. ...8. 'Sign off' or 'note' all orders in RED INK with the month, day, year, time, first initial and last name of person noting the orders.</p> <p>4. The medical record for patient #N6 indicated a written physician order from 05/24/12 that lacked documentation of verification or signing off by a nurse.</p> <p>5. The medical record for patient #N7 indicated two verbal orders from the physician on 08/15/12 that were signed by the physician, but not dated or timed according to policy, making it unable to determine adherence to the 48 hours time</p>		<p>Committee Meeting.</p> <p>As of December 26, 2012, any entry that is not dated timed and signed appropriately by Medical Staff will be flagged as a deficiency in Medical Records. The chart will be put in the incomplete chart room and the physician will complete the chart within the time frame allotted by Medical Staff Rules and Regulations.</p> <p>The Medical Records Director is responsible to implementing the deficiency check for dates/ times/ signature. This process will be completed by the Medical Records Clerks. Patterns of non-compliance by medical staff will be reported to the Medical Records Director. These patterns will be addressed with individual members of Medical Staff by the Medical Records Director. RNs and LPNs will make all efforts to enter verbal and telephone orders into Electronic Order Entry in CPSI as they are automatically dated and timed when authenticated. Some departments are not on an electronic health record for placing orders, therefore a verbal/ phone order must be written in the chart. If a verbal or telephone order is written in the chart, a tag will be placed by the order to alert the physician that the order needs to be signed, dated, and timed. The tag will be placed by the person writing the order at the time the order is written.</p>				

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	<p>frame.</p> <p>6. The medical record for patient #N8 indicated a written order on the Emergency Department Physician's Order sheet, timed at 1913, but not dated, that lacked documentation of verification or signing off by a nurse.</p> <p>7. The medical record for patient #N9 indicated a written order on the Emergency Department Physician's Order sheet, timed at 1900, but not dated, that lacked documentation of verification or signing off by a nurse.</p> <p>8. The medical record for patient #N10 indicated two sets of verbal orders from the physician on 10/02/12 and one set from 10/04/12 that were signed by the physician, but not dated or timed according to policy, making it unable to determine adherence to the 48 hours time frame.</p> <p>9. The medical record for patient #N11 indicated a written order on the Emergency Department Physician's Order sheet, timed at 12:40, but not dated, that lacked documentation of verification or signing off by a nurse.</p> <p>10 The medical record for patient #N13 indicated a set of telephone orders that</p>		<p>Medical Records Director 3,4,5,6,7,8,9,10,11,12) On December 21, 2012 a revision in the facility policy 41.16.06 titled "Physician Orders: Transcription of Physicians' Orders &amp; Routine Chart Checks for Inpatients, to include the following verbage: "Sign off" or "note" all orders in red or black ink, with the month, day, year, time, first initial and last name. If there is a signature key located on the form, the first and last initial may be used. The Emergency Room Director, the Inpatient Services Director, and the Surgical Services Director will educate staff on the policy revisions and re-educate on proper "noting" of orders. On December 21, 2012, the Medical Records Director spoke with the physicians identified in the deficiencies regarding proper authentication and entry of orders into the chart. A memo was distributed by the Medical Records Director to all medical staff regarding this change on December 21, 2012. On December 21, 2012, a signature key was added to the Physician's Orders Emergency Department form #1100 to bring awareness for documenting date AND time. The changes to the orders will be educated to the physicians and nursing staff by the Emergency Room Director. Information will also be presented by the Medical Records Director to all physicians at the January 9,</p>		

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	<p>lacked documentation of dates or times by both the nurse taking the orders and the physician signing them. The orders also lacked documentation of verification or signing off by a nurse.</p> <p>11. The medical record for patient #N18 indicated a written order on the Emergency Department Physician's Order sheet, timed at 1140, but not dated, that was timed and initialed in black ink, not red, to indicate signing off of the order. The record also indicated a set of printed physician orders from 10/13/12 that lacked documentation of verification or signing off by a nurse.</p> <p>12. The medical record for patient #N20 indicated a printed set of Pre-Operative Anesthesia Orders from 11/06/12 that lacked documentation of verification or signing off by a nurse.</p>		<p>2013 Medical Executive Committee Meeting.</p> <p>Every day the nursing staff will conduct daily chart checks. The chart checks will include a review of the date, time, and proper initials or signatures by the nursing staff. The findings from the review will be documented on a quality management tool that was developed on December 21, 2012. The tool will be forwarded to the ED, OR, and Inpatient directors on a daily basis. The directors will follow up with the staff members that are not in compliance as needed. This quality measure will continue until chart reviews are in 100% compliance with date, time, initials and signatures.</p> <p>As of December 26, 2012, any entry that is not dated timed and signed appropriately by Medical Staff will be flagged as a deficiency in Medical Records. The chart will be put in the incomplete chart room and the physician will complete the chart within the time frame allotted by Medical Staff Rules and Regulations.</p> <p>The Medical Records Director is responsible to implementing the deficiency check for dates/ times/ signature. This process will be completed by the Medical Records Clerks. Patterns of non-compliance by medical staff will be reported to the Medical Records Director. These patterns will be addressed with individual</p>		

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			members of Medical Staff by the Medical Records Director. RNs and LPNs will make all efforts to enter verbal and telephone orders into Electronic Order Entry in CPSI as they are automatically dated and timed when authenticated. Some departments are not on an electronic health record for placing orders, therefore a verbal/ phone order must be written in the chart. If a verbal or telephone order is written in the chart, a tag will be placed by the order to alert the physician that the order needs to be signed, dated, and timed. The tag will be placed by the person writing the order at the time the order is written. Medical Records Director, Emergency Room Director, Inpatient Services Director and Surgical Services Director	

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S001125	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(B)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(B) Operational and maintenance control records shall be established and analyzed periodically. These records shall be readily available on the premises.</p> <p>Based on document review and staff interview, the facility failed to ensure all medical equipment are monitored by the Bio-Medical Technician/Company as per hospital policy.</p> <p>Findings included:</p> <p>1. Safety Policy 4.11.03, last reviewed October 2010, states, "There is an established, scheduled preventive maintenance program for equipment relating directly or</p>	S001125	<p>1,2,3) The Safety Policy 4.11.03 Medical Equipment Management Plan was revised on 12/19/12 and states that the Director of Plant Operations will maintain a complete list of all medical equipment to evaluate and manage the preventive maintenance of the clinical equipment. It will be monitored on a monthly basis. Monthly monitoring for compliance. Updating the list each time a piece of equipment is removed from service and with each new equipment purchase. Director of Plant Operations</p>	01/17/2013			

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	<p>in-directly to patient care. The program is monitored by reports provided by the Safety Committee, by the Bio-Medical Technician/Company. All medical equipment is included in the identification/inventory rather than limit selection based on risk criteria."</p> <p>2. At 12:10 on 12/12/2012, staff member #20 indicated that the bio-medical company does not keep a complete medical equipment log for all medical equipment within the hospital.</p> <p>3. At 12:20 PM on 12/12/2012, staff member #2 indicated all the departments in the hospital are to keep track of any medical equipment that was not monitored by the bio-medical company. The staff member indicated he/she had to track down all preventive maintenance paperwork from each department of medical equipment that was requested. The staff member confirmed the bio-medical</p>			
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	company does not monitor a bio-medical equipment schedule for all equipment within the hospital.			

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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 720 SOUTH SIXTH ST MONTICELLO, IN 47960		
(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	
S001160	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on document review, the facility failed to ensure the hydrocollator located in the Physical Therapy Department was maintained the proper temperature as required by the manufacturer.</p> <p>Findings included:</p> <p>1. Model M-2 Chattanooga hydrocollator manufacturer states, "Never adjust the thermostat too high. The thermostat is extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature is 160 F to 165 F."</p> <p>2. The Hydrocollator Temperature Log for October 1st through December 11th were reviewed. The logs revealed the temperature for each day it was taken was 172 degrees Fahrenheit. The days the temperature was taken totaled 50 days.</p>	S001160	<p>The Model M-2 Chattanooga hydrocollator was locked out and tagged out on 12/12/12 and taken to the Bio-Med shop. The director of the Rehabilitation department has permanently discarded the equipment. A ThermoZone Continuous Thermal Therapy Device will be purchased to replace the Model M-2 Chattanooga hydrocollator. This will be added to the Master Equipment list and will have the preventive maintenance completed according to the manufacturer's recommendations and monitored by the Director of Plant Operations.</p> <p>The Safety Policy 4.11.03 Medical Equipment Management Plan was revised on 12/19/12 and states that the Director of Plant Operations will maintain a complete list of all medical equipment to evaluate and manage the preventive maintenance of the clinical equipment. It will be monitored on a monthly basis.</p> <p>The Model M-2 Chattanooga hydrocollator was permanently discarded. In the future, Safety</p>	12/12/2012	

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			<p>Policy 4.11.03 Medical Equipment Management Plan will be followed. Policy 4.11.03 Medical Equipment Management Plan states that the Director of Plant Operations will maintain a complete list of all medical equipment to evaluate and manage the preventive maintenance of the clinical equipment. It will be monitored on a monthly basis</p> <p>Director of Plant Operations The equipment was permanently discarded on 12/12/12. All new equipment purchased will be immediately added to the Medical Equipment Management Plan prior to placing in service.</p>		