

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  004779	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/16/2013
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NAME OF PROVIDER OR SUPPLIER  ST VINCENT DUNN HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 23RD ST BEDFORD, IN 47421
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S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State licensure survey.</p> <p>Facility Number: 004779</p> <p>Dates: 7-15-13 through 7-16-13</p> <p>Surveyors: Billie Jo Fritch, RN, MBA, MSN Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratorian</p> <p>QA: cloughlin 07/30/13</p>	S 000		
S 406	<p><b>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT</b></p> <p>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></p>	S 406	<p><i>ADMINISTRATOR</i></p>	

Indiana State Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

APR 19 1955

W. H. R.



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S 406	Continued From page 1  This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure inclusion of all services, including those services provided by contract, in the facility Quality Assurance and Performance Improvement (QAPI) program to ensure they are provided safely and appropriately.  Findings include:  1. Review of facility documents on 7-16-13 lacked evidence that the direct services of transcription and sleep lab and the contracted services of mobile lithotripsy and laundry were included in the facility QAPI program to ensure they are provided safely and appropriately. 2. An interview was conducted with B#1 on 7-16-13 at 1540 hours and confirmed that the direct services of transcription and sleep lab and the contracted services of mobile lithotripsy and laundry are not included in the facility QAPI program to ensure they are provided safely and appropriately.	S 406		
S 554	410 IAC 15-1.5-2 INFECTION CONTROL  410 IAC 15-1.5-2(a)  (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.  This RULE is not met as evidenced by: Based on observation, the facility failed to provide an environment that minimized risk for 1 surgery	S 554		

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S 554	Continued From page 2 department toured.  Findings include:  1. During tour of the surgery department beginning at 11:30 a.m. on 7/16/13, it was observed that the soiled utility room that contained biohazardous waste also had items including, but not limited to, video equipment, cysto table, carts, and tool boxes/carts stored in the room.	S 554		
S 726	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES  410 IAC 15-1.5-4 (c)(7)(A)(B)  (c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:  (7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following:  (A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.  (B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.	S 726		

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S 726	Continued From page 3  This RULE is not met as evidenced by: Based on observation and interview, the facility failed to ensure the confidentiality of patient records in 1 of 1 radiology film storage room toured.  Findings included:  1. While touring the radiology department on 7-16-13 at 1055 hours with B#5, it was observed that the radiology film storage room was unsecured, not monitored, and with easy access, allowing public access to confidential patient records.  2. An interview was conducted with B#5 on 7-16-13 at 1055 hours and confirmed that the film storage area is unsecured and not monitored with easy access to patient radiology film records; this practice allows public access to confidential patient records.	S 726		
S 952	410 IAC 15-1.5-6 NURSING SERVICE  410 IAC 15-1.5-6(d)  (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).  This RULE is not met as evidenced by: Based on blood transfusion policy review,	S 952		

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S 952	<p>Continued From page 4</p> <p>transfusion document chart reviews and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for three of ten patients.</p> <p>Findings include:</p> <p>1. On 7/15/13 at 2:30 p.m., the policy, "Administration of Blood and Blood Products", reviewed 1/23/13, read: "Indicate on transfusion record form (TRF) whether a blood warmer is being used. If so, document the serial #, start/end temperatures and verify warmer quality control (QC). Blood cannot be used past four (4) hours of the Blood Bank Issue time. When the blood bag is empty, the transfusionist ending the transfusion fills out the stop date/time on the flow sheet and signs as person discontinuing blood. "</p> <p>2. On 7/15/13 at 2:45 p.m., review of three patients receiving blood units indicated four of these received-units did not have complete documentation on the transfusion record form including:</p> <p>Patient #4 --Unit #41 administered on 7/02/13 at 1240: The unit was issued on 7/02/13 at 0925 and completed at 1435 which was 5 hours and 10 minutes in lieu of less than 4 hours.</p> <p>Patient #5 --Unit #51 administered on 7/02/13 at 0745: There was no signature of the person discontinuing or completing the transfusion. --Unit #52 administered on 7/02/13 at 0950: There was no signature of the person</p>	S 952		

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S 952	Continued From page 5 discontinuing or completing the transfusion.  Patient #6 --Unit #61 administered on 6/30/13 at 1044: There was no documentation to indicate whether a blood warmer was used.  3. On 7/15/13 at 3:30 p.m., staff member #1 indicated the missing documentation on the above-listed blood transfusion records had occurred.	S 952		
S1014	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES  410 IAC 15-1.5-7(c)  (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.  This RULE is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that single dose vials were discarded after opening and use for 1 surgery department toured.  Findings include:  1. During tour of the surgery department beginning at 11:30 a.m. on 7/16/13 and accompanied by staff members #6 and #N1, the	S1014		

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S1014	Continued From page 6  following was observed: (A) Two (2) opened single dose vials of Xylocaine-MPF 1% was observed in a cart in the patient holding area.  2. Staff member #N1 indicated during the tour that the Xylocaine was used for I.V. starts.	S1014		
S1118	410 IAC 15-1.5-8 PHYSICAL PLANT  410 IAC 15-1.5-8 (b)(2)  (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:  (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.  This RULE is not met as evidenced by: Based on observation and interview, the facility failed to maintain conditions to ensure the safety and well-being of staff and the public.  Findings included:  1. While touring the maintenance shop on 7-16-13 at 1010 hours with B#5, one unsecured acetylene tank was observed on the maintenance shop work bench creating an unsafe condition for facility staff and the public.  2. While touring an electrical room (Room 205) on 7-16-13 at 1015 hours with B#5, a moist, oily substance was observed seeping from under the	S1118		

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S1118	Continued From page 7  electrical panels creating an unsafe condition for facility staff and the public. 3. While touring a mechanical room (Room 204) on 7-16-13 at 1020 hours with B#5, twenty-five (25) unsecured fire extinguishers were observed on the floor of the mechanical room creating an unsafe condition for facility staff and the public. 4. An interview was conducted with B#5 on 7-16-13 at 1010 hours, 1015 hours, and 1020 hours respectively and confirmed the above unsafe findings.	S1118		
S1162	410 IAC 15-1.5-8 PHYSICAL PLANT  410 IAC 15-1.5-8(d)(2)(A)  (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:  (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.  This RULE is not met as evidenced by: Based upon policy/procedure review, clinical engineering reports, and staff interview, the laboratory failed to document preventative maintenance of required rotations per minute (rpm) testing for two of two centrifuges used for urinalysis and routine chemistry testing, in	S1162		

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S1162	<p>Continued From page 8</p> <p>accordance between the approved centrifuge policies and procedures and clinical engineering reports.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>On 7/16/13 1330 review of the policy, "Microscopic Examination of Urine Sediment", effective 3/28/13, read: "Centrifuge the tube for 5 minutes at 1500 rotations per minute (RPM)."</li> <li>On 7/16/13 at 1415 review of the clinical engineering report for centrifuge #3 (serial #394920), dated 7/01/13, used in urinalysis testing read: "Unit actual measured speed in RPM's: 3300 RPM, Unit Time Measured 15 minutes." This report was not in accordance with the requirements listed in the urinalysis policy/procedure of 1500 RPM and 5 minutes timer.</li> <li>On 7/16/13 at 1345, staff member #4 indicated there was no approved policy/procedure indicating the rpm and time required for centrifuging routine chemistry specimens. Since there was no approved routine chemistry policy/procedure for either RPM or time requirements, it could not be determined whether the RPM's or timer checks for centrifuges checked by clinical engineering, each on 7/01/13, was correct</li> <li>On 7/16/13 at 1430, staff member #4 indicated that both the urinalysis and routine chemistry centrifuge RPM and timer checks failed to match the testing results by clinical engineering.</li> </ol>	S1162		