

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
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NAME OF PROVIDER OR SUPPLIER ST VINCENT HEART CENTER OF INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 10580 N MERIDIAN ST INDIANAPOLIS, IN 46290
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 003284</p> <p>Survey Date: 12-3/5-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 12/07/12</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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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 1 contracted service (blood provider).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the contracted service of blood provider. 2. In interview, on 12-5-12 at 10:30 am, employee #A12 indicated no report for the contracted service of blood provider was submitted via the quality assurance process. 	S0270	<p>S270 During the onsite survey staff did not clearly articulate the reporting structure for the blood provider. Our current process involves the report out of quality monitoring of the blood provider to the Infection Prevention/Pathology Committee. The Infection Prevention/Pathology Committee reports to the hospital's overall quality committee, Operations Quality. Operations Quality reports directly to the governing board. We have provided education to staff on December 5, 2012 regarding the report out of quality monitoring of the blood provider. This will ensure that this deficiency will not occur in the future. The person responsible for the above plan of correction is the Vice President of Quality/Risk. This deficiency was corrected on December 5, 2012.</p>	12/05/2012	

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S0744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on document review, review of medical records, and interview, the facility failed to implement its policy for conscious sedation for 10 (N5, N6, N8-two procedures, N13, N18, N19, N21, N22, and N23) of 20 conscious sedation records reviewed.</p> <p>Findings included:</p> <p>1. Facility policy "Medical Record Entries", last reviewed/revised 10/2010, indicated on page 2, B that "All entries shall be legible and complete, dated, and timed".</p> <p>2. Facility policy "Procedural Sedation", last reviewed/revised 10/2012, indicated on page 1 "Sedation will be ordered by and supervised by the Licensed Independent Practitioner (LIP) credentialed for the administration of moderate/deep sedation"2, B that "All entries shall be legible and complete, dated, and timed"...on page 3, B, "Pre-Sedation and Documentation --1. The pre-sedation assessment determines the care, treatment, and services to be</p>	S0744	<p>S744 A valid History and Physical (which will include allergies, medication and an update to H & P as needed) and a complete pre-sedation assessment must be present on the chart before sedation begins. Documentation that the H & P has been reviewed by the provider will be present in the medical record.</p> <p>During the pre-procedure time-out, we will implement a mandatory "hard stop". This "hard stop" will ensure that the case will not proceed until a valid H & P and complete pre-sedation assessment is documented.</p> <p>Chart audits will be conducted on 100% of charts until 100% compliance is obtained. At that time quarterly audits will be done to assure we are maintaining 100% compliance.</p> <p>We have provided education to staff on the importance of completely and legibly documenting. In addition, written communication to the medical staff members will be sent out by December 31, 2012. The</p>	01/01/2013	

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	<p>provided to the patient 2. The pre-sedation assessment must be performed and documented in the medical record before moderate sedation may be administered, and includes the following.</p> <p>Refer to Attachment A: Adult Pre-Sedation Assessment (PSA).. C. Responsibility of the Licensed Independent Practitioner (LIP) ...3. ASA classification 4. Pre-sedation plan of care including: ...b.Determination of anticipated post-procedure needs of the patient"D. Responsibility of the Registered Nurse: 1. Nursing documentation including: ...iv. weight in kilograms, age, and height...vii. NPO status ... E. verification of medical record contents including:3. Pre-sedation assessment 4. Pre-sedation plan of care".</p> <p>3. Facility policy "Universal Protocol", last reviewed/revised 6/2011, indicated on page 2, B that "upon arrival in the Procedural Area...the caregiver will verify with the guest...the guest's identity, the procedure to be performed, any known allergies".... and page 2, C "Time Out" prior to initiation of Procedure... "the initiator will verify with the entire team: a. correct guest identity using 2 identifiers, b. agreement upon the procedure and accurate consent has been signed, c. correct side and site have been marked.. d. verify and document the</p>		<p>above processes will ensure that this deficiency will not recur in the future. The person responsible for this process will be the Chief Medical Officer. This deficiency will be corrected by January 1, 2013.</p>				

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	<p>pre-procedure antibiotic e. confirm the need to administer antibiotics or fluids..f. confirm any safety precautions...g. verify all relevant images and results are properly labeled and appropriately displayed".</p> <p>4. During review of medical records on 12-5-12 and 12-6-12 with A10, the following was noted:</p> <p>A. N5 had a right and left heart catheterization on 10-25-12 under conscious sedation and the Pre-Sedation Assessment (PSA) lacked documentation of:</p> <ol style="list-style-type: none"> i. the NPO status as to clear liquids. ii. the NPO status as to food/milk. iii. the medical history section contained assessments of: previous problems with anesthesia/sedation; airway abnormality; significant medical/surgical history; possible pregnancy; significant family history; smoking history; and alcohol/substance abuse; and an area to explain any YES answers; this section was blank except for the notation "Please see chart". <p>B. N6 had a left heart catheterization under conscious sedation on 10-23-12 and the PSA lacked documentation of:</p> <ol style="list-style-type: none"> i. weight. ii. planned procedural medications. 				

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	<p>C.</p> <p>a. N8 had a left heart catherization under conscious sedation on 10-20-12 and the PSA lacked documentation of :</p> <p>i. that allergies had been identified in the PSA under "Allergies" which stated "Multiple-see chart".</p> <p>ii. the medical history section contained areas for assessments of: previous problems with anesthesia/sedation; airway abnormality; significant medical/surgical history; possible pregnancy; significant family history; smoking history; and alcohol/substance abuse; and an area to explain any YES answers; this section was blank except for the notation "See H&P".</p> <p>iii. review of current medications and allergies.</p> <p>iv. weight.</p> <p>b. N8 had a left heart catheteriztion with stent placement under conscious sedation on 10-23-12 and the PSA lacked documentation of:</p> <p>i. weight.</p> <p>ii. that allergies had been identified in the PSA under "Allergies" which stated "See chart".</p> <p>iii. the medical history section contained assessments of: significant medical/surgical history and significant family history which were marked "Yes"</p>						

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	<p>but lacked any explanation of the positive findings other than "See chart".</p> <p>iv. review of current medications and allergies.</p> <p>v. under "Physical Exam" the areas for heart; lungs; airway; and mental status were not checked as "normal findings" and there was no notation of abnormal findings.</p> <p>v. signature/authentication by the Licensed Independent Practitioner.</p> <p>c. N8 was allergic to biaxin, levaquin, sulfa, doxycycline, macrobid, codeine, dilaudid, zantac, and imitrex. On the 10-23-12 PSA prior to stent placement, there was no notation of N8's 10-20-12 left heart catheterization.</p> <p>D. N13 had a bedside "esophagogastroduodenoscopy" (EGD) under conscious sedation on 10-17-12 and the PSA lacked documentation of:</p> <p>i. the indication for the procedure.</p> <p>ii. planned procedure.</p> <p>iii. NPO status as to clear liquids.</p> <p>iv. NPO status as to food/milk.</p> <p>v. signature of the Licensed Independent Practitioner.</p> <p>vi. the Physician Progress Note from 10-17-12 lacked any patient identification; no label or other form of patient identification.</p> <p>E. N18 had a left heart catheterization</p>			

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	<p>under conscious sedation on 10-4-12 and the PSA lacked documentation of:</p> <ul style="list-style-type: none"> i. review of current medications and allergies. ii. planned procedural medications. iii. under "Physical Exam" the areas for heart; lungs; airway; and mental status were not checked as "normal findings" and there was no notation of abnormal findings. iv. pre-sedation plan of care. v. post-procedure plan of care. <p>F. N19 had a electrophysiology study under conscious sedation on 10-1-12 and the PSA lacked documentation of:</p> <ul style="list-style-type: none"> i. NPO status as to clear liquids. ii. NPO status as to food/milk. iii. under "Physical Exam" the areas for heart; lungs; airway; and mental status were not checked as "normal findings" and there was no notation of abnormal findings. iv. weight. v. review of current medications and allergies. vi. documentation of the planned procedural sedation medications. <p>G. N21 had a colonoscopy under conscious sedation on 10-6-12 and the PSA lacked documentation of:</p> <ul style="list-style-type: none"> i. weight ii. NPO status as to clear liquids. 						

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	<p>iii. NPO status as to food/milk.</p> <p>iv. the signature/authentication of the RN</p> <p>v. the form was incorrectly dated as 10-5-12.</p> <p>H. N22 had a left heart catherization with stent placement under conscious sedation on 9-25-12 and the PSA lacked documentation of:</p> <p>i. NPO status as to clear liquids.</p> <p>ii. NPO status as to food/milk.</p> <p>iii. under "Physical Exam" the areas for heart; lungs; airway; and mental status were not checked as "normal findings" and there was no notation of abnormal findings.</p> <p>iv. review of current medication and allergies.</p> <p>v. the post-procedure plan of care.</p> <p>I. N23 had a left heart catherization under conscious sedation on 9-21-12 and the PSA lacked documentation of:</p> <p>i. review of current medication and allergies.</p> <p>ii. under "Physical Exam" the areas for heart; lungs; airway; and mental status were not checked as "normal findings" and there was no notation of abnormal findings.</p> <p>iii. review of current medication and allergies.</p> <p>iv. pre-procedure plan of care.</p> <p>v. post-procedure plan of care.</p>			

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	<p>5. Interview with A3 on 12-4-12 at 2:30 PM, A3 indicated:</p> <p>a. is a member of the Procedural Sedation Committee.</p> <p>b. a recent audit of medical records containing conscious sedation procedures in the cardiac catheterization unit had been completed and showed PSA records for cardiac catheter lab procedures under conscious sedation with incomplete documentation results which were being addressed through the Procedural Sedation Committee; that the facility plans to align its processes, forms (paper and computer), policies and procedures to streamline documentation while maintaining safety to improve compliance with facility expectations.</p> <p>c. that the History and Physical must be in the medical record and available for review by caregivers prior to any conscious sedation procedure and that the facility "Universal Protocol" (Time-out) is an additional safeguard to assure that all team members concur with the required elements of the "time-out" per facility policy to include: patient's identity, procedure, allergy status, correct side and site marked; time of pre-procedural antibiotic administration, if ordered, safety precautions, availability of all relevant images and results.</p> <p>d. that the physician who performs the</p>				

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	<p>procedure in the cardiac catheterization lab is often different than the physician who dictated the patient's history and physical (H & P) and that Nurse Practicioners and Physician Assistants may dictate an H & P which must then be authenticated by a physician.</p> <p>6. Interview with A13 on 12-5-12 at 10:30 AM, A13 indicated:</p> <p>a. A13 is a member of the Procedural Sedation Committee.</p> <p>b. reviewed the above medical record findings and verified the findings.</p> <p>c. that facility policy requires completion of all the fields in the PSA for conscious sedation procedures.</p> <p>d. that revisions to the PSA and facility policies are under review with anticipated completion sometime in early 2013.</p> <p>e. that the PSA functions to serve as an assessment tool for the LIP and the RN to tailor the patient's pre-sedation and post-sedation plan of care; to make all healthcare providers aware of the patient's pertinent history and physical findings, allergy status, NPO status as to clear liquids and food/milk, current medications, pertinent laboratory findings, ASA category, pertinent laboratory /diagnostic tests, etc. which must be reviewed and analyzed to develop an appropriate individualized plan of care prior to the initiation of conscious</p>						

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	<p>sedation, and that the approved form should be completed per facility policy.</p> <p>f. that the procedure "time-out" is a safeguard which occurs after the patient's pre and post sedation assessment and plan of care have been determined.</p> <p>g. that the LIP performing the patient's History and Physical is often not the LIP performing the conscious sedation procedure and that in the cardiac cath lab the procedures in the sample were often performed several days after the H & P had been dictated during which the patient's mental and/or physical condition, medications, etc. could have changed; therefore, the safety of the patient and the development and documenting of an appropriate individualized plan of care are dependent on the LIP who orders and supervises the administration of conscious sedation, and the RN who administers and monitors the patient during conscious sedation during the procedure, both reviewing the data in the PSA prior to a procedure and documenting that this has been accomplished in the medical record.</p> <p>g. that it cannot be reliably determined, based upon the above medical record findings, that the LIP ordering and supervising the administration of conscious sedation, and the RN involved in assessing and determining a pre and post-sedation plan of care, had reviewed and incorporated into the plan of care all</p>			

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	the information required by facility policy prior to implementing the conscious sedation procedueres.			

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S0748	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3). Based on document review and interview, the facility failed to assure that the licensed independent practitioner signed/authenticated the Pre-Sedation Assessment form as required by policy for 1 of 1 bedside procedures whose medical records were reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Facility policy "Authentication of Medical Record Entries", last reviewed/revised 3/2011 provided "All clinical entries shall be dated, timed, and authenticated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished". 2. Review of medical records on 12-4-12 at 3:20 PM indicated: <ol style="list-style-type: none"> a. N13 had an "esophagogastroduodenoscopy" (EGD) under conscious sedation on 10-17-12. b. the pre-sedation assessment record lacked a signature, date, and time of the physician who performed the procedure. 	S0748	<p>S748 Written communication to the medical staff to educate them on the importance of dating, timing and authenticating medical record entries will be sent in December 31, 2012. The Health Information Management (HIM) department will conduct ongoing audits to ensure that medical record entries are properly documented.</p> <p>The above processes will ensure that this deficiency will not recur in the future. The people responsible for these processes will be the Chief Medical Officer and the Process Leader for HIM department. This plan of correction will be completed by January 10, 2013.</p>	01/10/2013

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	3. During interview with A10 on 12-4-12 at 3:30 PM, A10 verified the findings in the medical record to include lack of physician signature, date, and time on the pre-sedation assessment record for N13's procedure as required by facility policy.			

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NAME OF PROVIDER OR SUPPLIER ST VINCENT HEART CENTER OF INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 10580 N MERIDIAN ST INDIANAPOLIS, IN 46290			
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S0754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and interview, the facility failed to obtain informed consent for a procedure per facility policy for 1(N13) of 1 medical records reviewed involving a bedside procedure and for 2 (N2 and N3) of 3 transfers from the Emergency Department.</p> <p>Findings included:</p> <p>1. Facility policy "Informed Consent", last reviewed/revised 3/2011, indicated on page 2 that "the consent of the guest must be obtained before any surgical procedure"... "the guest or his personal representative will sign an informed consent authorizing a specific procedure to be performed" and on page 3 "although a written consent is preferred, verbal consent, in person or by phone, is valid; in such a case 2 RNs should confirm the</p>	S0754	<p>S754 Physicians and nurses will receive education on the informed consent process by January 10, 2013. The HIM department will conduct ongoing audits to ensure that medical records contain properly documented informed consents.</p> <p>The above processes will ensure that this deficiency will not recur in the future. The people responsible for these processes will be the Chief Medical Officer, Chief Nursing Officer, Process Leader for HIM department and Process Leader for patient unit. This plan of correction will and be completed by January 10, 2013.</p>	01/10/2013			

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	<p>consent and the nurse will include a progress note in the medical record that documents the conversation" and on page 5 "Generally an adult..can consent to health care..an adult who is capable of making health care decisions may fill out and sign this form with assistance from medical staff in order to consent to specific treatment...If the guests wants to, he/she may authorize another individual to consent to health care in the event that he/she becomes incapable of consenting to his/her own care (see hospital policy "advance medical directive)".</p> <p>2. Facility policy "Transfrer of Guests to Another Acute Care Facility", last reviewed/revised 3/2011, indicated on page 2 that "both the consent for transfer and physician certification will be completed if a guest is transferred to the following acute care facilities: 1. another acute care hospital 2. long term acute care facility 3. acute (in-patient) unit".</p> <p>3. Review of medical records on 12-4-12 at 2:00 PM indicated: A. i. N13 had an "esophagogastroduodenoscopy" (EGD) under conscious sedation on 10-17-12. ii. an informed consent form obtained by telephone dated 10-17-12 for an EGD was witnessed by 2 RNs and included a</p>			

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	<p>statement "Phone consent given" but lacked the name of the person providing the consent.</p> <p>iii. the physician performing the EGD noted in the dictation of the procedure performed that "the procedure, risks, and benefits were explained to the patient. The patient appeared to understand this and, thus, was given an opportunity to ask questions, whereupon informed consent was obtained".</p> <p>iv. there was no informed consent form for an EGD on 10-17-12 signed by N13 in the medical record.</p> <p>v. there was no advance directive (AD) in the medical record.</p> <p>vi. there was no medical power of attorney (POA) in the medical record.</p> <p>B. N2 presented to the ED on 11-30-12 with a small bowel obstruction and was transferred to an acute care hospital; the "Consent/Request to Transfer to Another Acute Care Hospital" form lacked documentation that N2 had consented to the the following: Understanding the content of this Consent/Request to Transfer to Another Acute Care Hospital I hereby: <input type="checkbox"/> Consent to the transfer <input type="checkbox"/> Refuse the transfer" Neither box was checked on the form.</p> <p>C. N3 presented to the ED on 11-25-12</p>				

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	<p>with renal failure and was transferred to an acute care hospital; the "Consent/Request to Transfer to Another Acute Care Hospital" form lacked documentation that N3 had consented to the the following: "Understanding the content of this Consent/Request to Transfer to Another Acute Care Hospital I hereby: (box was present in front of each of these two options)</p> <p>_____ Consent to the transfer _____ Refuse the transfer"</p> <p>Neither box was checked on the form.</p> <p>4. During interview with A10, on 12-5-12 at 2:30 PM, A10 verified:</p> <p>a. an EGD is a diagnostic procedure which requires informed consent be obtained prior to the procedure per facility policy.</p> <p>b. the findings in the medical record including that N13 did not have an Advance Directive or a POA in the medical record.</p> <p>c. the progress notes for N13 lacked any documentation of the telephone consent procedure; the identity of the person who provided the telephone consent; or the authority under which such a person would have been acting and as such was not in compliance with facility policy for obtaining informed consent.</p> <p>d. the informed consent the physician indicated had been obtained was not</p>						

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	<p>documented on an informed consent form; there was no informed consent form signed by N13 and therefore the physician did not comply with faciity policy.</p> <p>e. on the date of the procedure the nurse documented on the Pre-Sedation Assessment that N13 had altered mental status but lacked any documentation of a medical finding that N13 was not competent to consent and sign an informed consent form.</p> <p>f. the "Consent/Request to Transfer to Another Acute Care Hospital" for N2 and N3 were not completed as required per facility policy.</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). Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to follow approved medical staff policies/procedures for the administration of five of seven transfusions reviewed.</p> <p>Findings included: 1. On 12/03/12 between 12:00 p.m. and 1:00 p.m., review of PolicyStat ID: 177403 Effective Date: 03/2012, Approved Date: 03/2012 revealed: "DEFINITIONS: Licensed independent practitioner (LIP) - a medical doctor (MD), doctor of osteopathy (DO) or an advance practice registered nurse (APRN) with prescriptive authority licensed by the State of Indiana. POLICY: TRANSFUSION ORDER: A. Blood/blood products are ordered by an LIP. PREPARING FOR TRANSFUSION: STEPS OF PROCEDURE 5. Obtain and document</p>	S0952	<p>S952 a. nursing staff will receive education on the importance of performing vital checks prior to the initiation of transfusion. b. This deficiency is related to synchronization of our clocks. Transfusion cannot be initiated before the blood is pick up (there would be nothing to transfused). Therefore, we will utilize one timing tool (computer clock) to ensure the time is recorded properly. c. We have changed our policy to include Physician Assistants as authorized to order transfusions. d. All staff will received education on the importance of completely filling out documentation (including date, time and signature) and answering all questions. e/f. All staff will received education on the importance on dating and timing start and finish times and indicating person performing this. The Process Leader for Laboratory will conduct an audit on a sample of medical records</p>	01/10/2013			

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	<p>pre-transfusion vital signs on the Blood Transfusion Flowsheet or on the Transfusion Record (paper). Time taken must be within 1 hour of the time you pick up the blood from the Blood bank.</p> <p>7. Document the date and time the transfusion was initiated. 14. Complete documentation: Date and time the infusion was completed."</p> <p>2. On 12/04/12 between 1:00 p.m. and 4:00 p.m. review of transfusion records revealed the following failures to follow approved medical staff policies and procedures:</p> <p>a. Transfusions #'s 1,2, and 7 had pre vitals recorded as the same time as the initiation of the transfusion.</p> <p>b. Transfusion #7 was initiated before the blood was picked up from the blood bank.</p> <p>c. Transfusion #3 appears to have been ordered by a PA (Physician Assistant) who is not defined as a LIP in the facility policy.</p> <p>d. Transfusions #3 and 6 did not have the transfusion reaction question answered yes or no.</p> <p>e. Transfusion #3 did not have the date and time the infusion stopped or by who.</p> <p>f. Transfusion #6 did not have the date and time the infusion stopped.</p> <p>3. In interview on 12/4/12 between 3:00 p.m. and 3:30 p.m., staff person #3 acknowledged there was no LIP listed as</p>		<p>for blood transfusion patients to ensure proper documentation of procedure until 100% compliance is reached. The above processes will ensure that these deficiencies will not recur in the future. The people responsible for these processes will be the Chief Nursing Officer and Process Leaders. This plan of correction will be completed by January 10, 2013.</p>				

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	the ordering entity for transfusion #3.			

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S1022	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on documentation and observation, the hospital failed to appropriately store a medication in 2 instances.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled Medication Security, approved 6/2009, indicated all medication storage areas shall be either locked or otherwise secured in such a way to prevent access to medications by unauthorized persons.</p> <p>2. On 12-3-12 at 12:25 pm in the presence of employees #A8 and #A9, it was observed in a hallway on the 4th floor across from an elevator, there was a cart with 1 vial of heparin 30 ml in a drawer. The cart was unsecured and there were no hospital personnel in or observing the area. Thus, the medication was accessible to unauthorized persons.</p>	S1022	<p>S1022 On December 3, 2012 the Pharmacy Process Leader informed the Director of Dialysis (dialysis is a contracted service) about the unsecured heparin vial found atop of a dialysis cart. The Director of Dialysis acknowledged that this not appropriate and ensured that she will educate her staff on the importance of safely securing medications. This education will take place by January 10, 2013. The above process will ensure that this deficiency will not recur in the future. The person responsible for this plan of correction is the Process Leader for PCCU/Dialysis. Process Leader for PCCU/Dialysis will conduct ongoing safety rounds (walk-through) to ensure medications are properly secured. Staff will be educated on the need to return the recovery kit to the secure medication room (even if the box still has its lock unbroken). This education will</p>	01/10/2013	

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	3. During tour of the 3rd floor PCCU unit on 12-4-12 at 11:40 A.M and in the presence of A5, A6, and A10, a gray and red travel box containing medications was observed in an unsecured area (on the countertop of the nurse ' s station desk).		ensure that this deficiency will not recur in the future. The people responsible for this plan of correction are the Process Leaders for the nursing areas. This plan of correction will be completed by January 10, 2013.		

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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 observation and document review, the hospital did not follow its policy and created a condition which resulted in a hazard to patients, public or employees in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-03-10 at 11:20 pm in the presence of employees #A8 and #A9, it was observed in the bed shop there were 2 carbon dioxide tanks on the floor unsecured by chain or holder. Review of a hospital policy entitled Precautionary and Safety Measures for the Storage, Transportation and Use of Therapeutic Gases, approved 10/2012 indicated cylinders should always be secured by a strap, stand, or cart. If any of the above tanks were knocked 	S1118	<p>S1118 The two unsecured carbon dioxide tanks in the bed shop located on the 4 th floor were immediately removed and placed in an approved tank holding cart during the onsite licensure survey. In addition, the facilities staff took a portable cart to the bed shop for tank storage. The Facilities Process Leader will provide education to staff on the proper place to store all pressure filled cylinder tanks. The Facilities Process Leader will conduct ongoing safety rounds to ensure that tanks are properly secured. This education will ensure that this deficiency will not recur in the future. The person responsible for this plan of correction is the Facilities Process Leader. This plan of correction will be completed by January 10, 2013.</p>	01/10/2013			

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	over and broke the head off the compressed cylinder, it could result in harm to people and/or property.			

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S1150	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.</p> <p>Findings:</p> <p>1. On 12-3-12 at 2:25 pm in the presence of employees #A8 and #A9, it was observed in the soiled utility room in the biomedical engineering room there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S1150	<p>S1150 During the onsite licensure survey, the Facilities Process Leader removed the hose and disposed of it. There was no use for the hose to be on the faucet and the hose will not be need in the future. This plan of correction will ensure that this deficiency will not recur in the future. The person responsible for this plan of correction is the Facilities Process Leader. This plan of correction was completed on December 4, 2013.</p>	12/05/2012	

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S1172	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on policy review, observation, and interview, the facility failed to reduce the risk of transmission of disease to patients, health care workers, and the public by not providing an environment free of dust accumulation, soiled surfaces, soiled floors, and by not assuring the recommended contact time for the facility approved disinfection agent used on 2 of 2 in-patient units toured.</p> <p>Findings included:</p> <p>1. Facility policy "Pharmacy and Drug Rooms", last reviewed/revised 1/2012, provided an environmental services frequency schedule for pharmacy and</p>	S1172	<p>S1172 A new Duty List has been created which is a detailed time specific schedule for each employee, and is given out every day. The duty list provides every area that needs to be cleaned and gives specific instructions of what type of cleaning needs to take place. The duty list has a line to check off and initial that each area has been cleaned as instructed. The duty list also includes nurse's stations, med rooms, ACCU check docking stations, etc... The manager also signs off on the duty list, after ensuring the cleaning has been completed to departmental standards. New manager Am/Pm checklists have been created to ensure inspections are occurring.</p>	12/31/2012			

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	<p>drug rooms to include daily: "dust sills, ledges, and other horizontal building and furniture surfaces"... "spot clean walls, doors, door facings, columns....to remove hand prints, smudges, and other obvious soil". "use a clothe and germicidal detergent from a spray bottle". ... "dust mop non-carpeted floors...use a wet mop and germicidal detergent solutions".</p> <p>2. Facility policy "Nurses Station", last reviewed/revised 1/2012, provided an environmental services frequency schedule for nurses stations to include daily: "dust sills, ledges, and other horizontal building and furniture surfaces"... "spot clean walls, doors, door facings, columns.... to remove hand prints, smudges, and other obvious soil".. . "damp dust and disinfect telephones"...clean dispensers, sinks, countertops, and metal surfaces...use germicidal detergent solution to remove all obvious soil from paper towel dispensers, soap dispensers, plumbing fixtures, handles, push plates, partitions, kick plates, door handles, light switches, etc."</p> <p>3. During tour of two in-patient PCCU units on second and third floor on 12-4-12 at 11:45 AM and in the presence of A5, A6 and A10, the following were observed:</p>		<p>These checklists include a minimum of 3 manager quality inspection rounds a day. The checklist also includes Nurses Stations, med rooms, ACCU check docking stations, and etc... Upon completion of the checklist for the day, the manager signs off on the checklist for the review of the departmental director. The EVS Director reviews the prior day inspections and comments every morning, the director signs off upon review. Documented re-training will occur for all the housekeepers to ensure quality and thoroughness of cleaning standards as set forth by hospital policy. All EVS employees will have a documented training to ensure their knowledge of Virex II 256 kill time of 10 minutes, and training will take place to ensure knowledge of all products. All Virex II 256 bottles will have a label added to them that will read of the 10 minute kill time. Managers will randomly ask team members during supervisor rounds the kill time of the disinfectant to ensure ongoing training and knowledge. All EVS team members will also be re-trained on proper cleaning techniques to ensure high quality results for our patients, guest, and staff. These processes will ensure that these deficiencies will not recur. The person responsible for this plan of correction is the Environmental Services Director of Operations.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150153		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
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	<p>a. medicine room on the second and third floor had accumulation of dust, paper, and plastic vacutainers on floor in corners and behind moveable equipment and had dust and other debris accumulated on surfaces.</p> <p>b. the floor in the waking areas of these medicine rooms was dirty with dust accumulation, scuff marks, and was dull in appearance.</p> <p>c. the nurses stations on the in-patient units on the 2nd and 3rd floor had cabinets, counters, telephones, fax machines, and other work areas with accumulation of dust, debris, and obviously soiled areas on high contact surfaces and other horizontal and vertical surfaces.</p> <p>d. the docking stations (8) for the Accu Chek blood glucose meter units on the 2nd and 3rd floor in-patients units were observed to be soiled with smudges, dried liquid stains, and dust accumulation on the outer areas as well as the recessed area surrounding the connector pins.</p> <p>4. Interview with A12 on the 2nd floor in-patient unit on 12-4-12 at 12:35 AM in the presence of A5, A6, and A10, A12 indicated:</p> <p>a. A12 is a contracted housekeeper who works on both 2nd and 3rd floor.</p> <p>b. the required kill time for the approved disinfectant solution (Virex II 256) is 2</p>		This plan of correction will be completed by December 31, 2012.				

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	<p>minutes and that after 2 minutes or so of wet contact of the Virex with patient room equipment and furniture, A12 wipes the surfaces dry.</p> <p>c. that this has been A12's work practice when cleaning patient rooms-to leave the Virex wet for approximately 2 minutes and then wipe dry.</p> <p>4. Interview with A11, Assistant Director of Environmental Services of the contracted housekeeping service on 12-4-12 at 11:00 AM, A11 indicated:</p> <p>a. a frequency schedule of housekeeping duties is used to denote the cleaning schedules of various areas of the in-patient units on the second and third floors.</p> <p>b. supervisors inspect the in-patient units two to three times a day for satisfactory completion of tasks.</p> <p>c. a log was presented showing inspection by supervisors of nurse's stations; however, the documentation for the previous 4 days was not produced. The documentation of 11-29-12 and prior showed that the nurses stations had been inspected and were marked "satisfactory"; the list on the log did not include a category for medicine rooms and therefore it could not be determined when and who had cleaned/inspected these areas on the 2nd and 3rd floor.</p> <p>d. could not explain how the nurses</p>				

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	<p>stations on the 2nd and 3rd floor had been marked "satisfactory" when the areas contained dust, debris, and soiled surfaces and equipment for which ES was responsible for cleaning.</p> <p>e. A12 is a new employee but has completed the orientation and training provided by the contracted environmental services contractor and should have known and been using Virex for 10 minutes to achieve disinfection of patients' rooms.</p> <p>f. the documentation of supervisory inspections of housekeeping services from 11-30-12 to 12-4-12 on the 2nd and 3rd floor PCCU units was not provided after requested, prior to exit.</p> <p>g. environmental services does not clean the accu-chek machines or docking stations as that is a nursing staff responsibility.</p> <p>5. Interview with A9, the infection control preventionist, on 12-5-12 at 10:30 AM, A9 indicated:</p> <p>a. nursing staff are responsible to clean the accu-chek cases and docking stations.</p> <p>b. manufacturer's recommendation for approved disinfectants/cleaners and procedure was not produced after request.</p> <p>c. that the docking stations should be cleaned on a regular schedule and as needed, with a manufacturer and Infection Control approved disinfectant with</p>			

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	<p>careful attention to prevention of disinfectant solution contacting the connector pins.</p> <p>d. dirty docking stations, work surfaces, accumulations of dust and debris on the in-patient units in the medicine rooms and nurses stations poses a risk of cross-contamination of infective microorganisms to staff.</p> <p>e. the kill time for Virex II 256 is 10 minutes of the solution wet on surface prior to wiping dry and failure to allow the full 10 minutes of wet time prior to wiping dry means that microorganisms cannot be reliably determined to have been killed; thus posing a risk to patients, staff, and visitors of cross-contamination.</p>				