

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  153039		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/01/2012	
NAME OF PROVIDER OR SUPPLIER  HOWARD REGIONAL HEALTH SYSTEM-WEST CAMPUS SPEC				STREET ADDRESS, CITY, STATE, ZIP CODE 829 N DIXON RD KOKOMO, IN 46901			
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 4/30/2012 through 5/1/2012</p> <p>Facility Number: 003868</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 05/10/12</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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S0554	<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, manufacturer's directions, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p> <p>Findings included:</p> <p>1. During the tour of the 28-bed patient care unit, beginning at 9:25 AM on 05/01/12, accompanied by staff member #A1, the following observations were made:</p> <p>A. Lab tubes with medium in the drawer of the med cart, 1 yellow top expired 01/2012, 1 green top expired 09/2011, and 1 blue top expired 09/2011.</p> <p>B. Two of two Saf-Fixative containers with fluid with an expiration date of 11/08/11 in a cabinet in the medication room.</p> <p>C. Lab tubes in small baggies in the crash cart, 1 blue top tube expired 04/2012, 1 yellow top tube expired 04/2012, 1 yellow top tube expired 02/2012, and 1 green top</p>	S0554	To correct having outdated supplies in the nursing area a weekly checklist has been developed which includes all locations that were cited. Weekly completion of this checklist will prevent this deficiency in the future. Claudia Lowry, Director of Nursing, is responsible for ensuring the weekly checklist is completed and supplies are current.	05/21/2012

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	<p>tube expired 03/2012.</p> <p>D. A small plastic container with 6 open bottles of Comfort Accu-Check Glucometer control solution, along with the opened boxes, labeled with "Opened 12/10 Discard 3/10" in a bottom cabinet near the crash cart.</p> <p>E. A baggie containing 4 open bottles of Comfort Accu-Check Glucometer control solution labeled with "Opened 3/10 Discard 6/10" on a shelf behind the glucometer supplies.</p> <p>2. The manufacturer's directions on the labels of the glucometer control solution were to discard the bottles 90 days after opening.</p> <p>3. At 10:15 AM on 05/01/12, staff member #A6 indicated the crash cart was due to be checked for outdated supplies today after the medications were checked by pharmacy and had not been done yet. He/she acknowledged 2 lab tubes just expired yesterday, but 2 others expired 02/2012 and 03/2012. He/she also indicated he/she thought the glucometer control solution was good until the manufacturer's expiration date, but could not explain why there were so many opened bottles.</p> <p>4. At 10:20 AM on 05/01/12, staff member #A7, indicated he/she supplies</p>			

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	the control solution to the unit, but stocks it in the original containers and did not remove it from the boxes.			

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S0596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on documentation review and staff interview, the facility failed to ensure "Triple Team Heavy Duty Washroom Cleaner" was an EPA-registered hospital disinfectant.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. CDC guidelines for Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient-Care areas of Health Care facilities was to select an EPA-registered disinfectants and use them in accordance with the manufacturer's instructions.</li> <li>2. The "Triple Team Heavy Duty Washroom Cleaner" that was mounted on the wall in the diluting station of the</li> </ol>	S0596	<p>"Triple Team Washroom Cleaner" was permanently removed from housekeeping supply inventory stock and disposed of per MSDS requirement. All housekeeping chemicals will garner approval through Infection Control Department prior to use. The Support Services Manager was responsible for the removal and disposal of "Triple Team Washroom Cleaner" and is also responsible for ongoing monitoring of chemical inventory and Infection Control Department approval.</p>	05/02/2012	

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	<p>Housekeeping Room indicated it was not an EPA registered hospital disinfectant.</p> <p>3. At 3:45 PM on 4/30/12, staff member #4 (housekeeper) indicated the Triple Team was used on counters in the patient rooms. The staff member indicated he/she does not know what the kill time is.</p> <p>4. At 3:50 PM on 4/30/12, staff member #2 indicated Triple Team had a 10-minute kill time.</p>			

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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).</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure restraint orders were written and authenticated according to policy for 3 of 3 patients with restraints in place (#N6, N11, and N12).</p> <p>Findings included:</p> <p>1. The facility policy "Restraint: Physical Patient, Use of and Use of Form: Protective Restraint Record", last revised 5/10, indicated on page 3, "...2. Physician Order: Note: Immediate protective restraint may be instituted by the nurse without an order; however, the verbal or written order must be obtained within 12 hours of the time the restraints were applied. A written order, based on an examination of the patient by the physician, is required within 24 hours of the initiation of restraint. If the initiation of restraint is based on a significant change in the patient's condition, the RN will immediately notify the physician."</p>	S0748	<p>We reviewed current process and the 24 hour Restraint Order Form is not being signed in a timely manner because the form is not adequately flagged or in a readily accessible location for the attending physician. Once there is a physician order for a restraint, the following process will be followed to correct deficiencies surrounding the restraint process: Restraint Order Form will be completed by an RN on the night shift (while restraint order is still in effect). Completion of the Restraint Order Form on the night shift allows sufficient time for the physician to complete his daily patient rounds (24 hour exam) within the permitted time period. The Day charge RN will be responsible for ensuring the form is completed in it's entirety before submission to the physician for signature. This will include selection of type of restraint. The Day charge RN will put the Restraint Order Form with the attending and on call physician's clipboard to ensure timely completion of the form while the physician is doing daily patient rounds (24</p>	05/25/2012			

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	<p>2. The medical record for patient #N6 indicated a Restraint Order Form without documentation of the type of restraint used, signed by the nurse at 0000 on 12/09/11, but not signed by the physician until 0720 on 01/01/12. The record had another Restraint Order Form for a Lap Buddy, signed by the nurse at 0000 on 12/10/11, but not signed by the physician until 0720 on 01/01/12. A third restraint form was signed by the nurse at 0000 on 12/11/11, but not signed by the physician until 1037 on 12/13/11.</p> <p>3. The medical record for patient #11 indicated a Restraint Order Form signed by the nurse at 0000 on 12/22/11 and indicated a physician signature, but without a date or time. The record had another Restraint Order Form signed by the nurse at 0100 on 12/23/11, but not signed by the physician until 0923 on 12/25/11.</p> <p>4. The medical record for patient #N12 indicated a Restraint Order Form signed by the nurse at 0040 on 02/15/12, but not signed by the physician until at 0946 on 02/24/12. The record had another Restraint Order Form signed by the nurse at 2400 on 02/17/12, but not signed by the physician until 0938 on 02/20/12. A third restraint form was signed by the nurse at 2400 on 02/18/12, but not signed by the</p>		<p>hour exam) on the patients. All applicable physicians have been notified of this change in process and are supportive. We are confident patients are examined by a physician on a daily basis, 7 days a week per hospital policy, which is supported by daily medical chart documentation although missing physician signatures on restraint forms could portray otherwise. We believe this process change will ensure the restraint form is signed by the physician in a timely and accurate manner. Restraint policy will be updated accordingly to reflect this change in process. Nursing staff will be educated on this process at a nursing department meeting on 5/21/12. These deficiencies will be prevented in the future by instituting daily process oversight by the day charge RN. Claudia Lowry, Director of Nursing, is responsible for this action plan.</p>				

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	<p>physician until 0938 on 02/20/12.</p> <p>5. At 1:30 PM on 05/01/12, staff member #A1 confirmed the medical record findings and indicated it could not be determined whether the physician performed an exam within 24 hours as per 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).</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure physician orders and policy were followed regarding blood transfusions for 5 of 6 patients receiving blood transfusions (#N1, N6, N8, N9, and N10).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Blood Product Administration: Packed Red Cells, Frozen Plasma", last reviewed 04/11, indicated, "...21. Vital signs are to be monitored closely and recorded for each unit of blood administered. ...30..Complete Blood Product Transfusion form by filling in vital signs."</li> <li>The facility policy "Correction of Medical Records", last reviewed 04/11, indicated, "...1. If an error is made in</li> </ol>	S0952	<ol style="list-style-type: none"> <li>We reviewed the Blood Transfusion process and found that there is opportunity for error, since all blood transfusions do not require Lasix and there are three documentation locations associated with the blood transfusion process. Our goal is to make this process less cumbersome which will reduce the opportunity for error. To correct this deficiency the following process will be implemented and Blood Transfusion policy will be updated accordingly to reflect these changes:A new form will be implemented entitled Blood Transfustion Protocol/Orders. This form will be on red paper so it is eye-catching. This form will outline the steps in the Blood Transfusion process and serve as the physician order form and nursing documentation form for the blood transfusion process. This form does not take the place of the blood transfusion form</li> </ol>	05/29/2012			

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	<p>charting in the record, draw a single line through the incorrect information. Initial and date the entry and indicate the reason for the error. 3. If a pen or other writing utensil is used, the entry in the record must not be rendered unreadable."</p> <p>3. The medical record for patient #N1 indicated a physician order from 03/02/12 to transfuse 2 units of packed red blood cells (PRBCs) with 20 milligrams (mg.) of Lasix in between the units. The Medication Administration Record (MAR) indicated the order transcribed, but lacked documentation that the Lasix was given.</p> <p>4. The medical record for patient #N6 indicated a physician order from 12/13/11 to transfuse 2 units of packed red blood cells (PRBCs) and to give 20 mg. of Lasix intravenously push (IVP) between the units. The MAR indicated the order transcribed, but lacked documentation that the Lasix was given. The Blood Product Transfusion form had the time obtained from the blood bank, the time for the pre-transfusion vital signs, the blood start time, and the time for the 15 minute vital signs written over/changed making it unable to determine adherence to policy.</p> <p>5. The medical record for patient #N8</p>		<p>required by the lab/blood bank. This new form and blood transfusion process requirements will be reviewed with nursing staff at a nursing department meeting on 5/21/12. This deficiency will be prevented in the future by having one location for all blood transfusion orders and corresponding nursing documentation. Claudia Lowry, Director of Nursing, is responsible for action plan implementation and routine monitoring for compliance. 2. Incorrect medical error correction will be addressed by adding open medical charts to a weekly checklist being completed by the Director of Nursing. Medical Records staff will also audit the medical record for incorrect corrections prior to the medical record being closed. If incorrect medical error corrections are found they will be flagged for correction by the original author of that entry while the medical chart is still open. A copy Correction of Medical Records policy will be placed in the front of each medical chart for staff reference. This deficiency will be corrected in the future by the weekly checklist, Medical Records audit and subsequent correction of incorrect medical error corrections prior to the medical record being closed. Claudia Lowry, Director of Nursing, is responsible for the weekly checklist and ensuring ongoing compliance</p>				

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	<p>indicated a physician order from 03/09/12 to transfuse 2 units of packed red blood cells (PRBCs) with 20 milligrams (mg.) of Lasix in between the units. The Medication Administration Record (MAR) indicated the order transcribed, but lacked documentation that the Lasix was given.</p> <p>7. The Blood Product Transfusion form for patient #N9, who received blood on 03/02/12, had the date the blood was obtained from the blood bank documented as 3-2-13. All of the other documentation on the form was 03/02/12.</p> <p>8. The Blood Product Transfusion form for patient #N10, who received blood on 03/03/12, had the times for the post vital signs and stop time written over/changed making it unable to determine adherence to policy.</p> <p>9. At 1:30 PM on 05/01/12, staff member #A1 also reviewed the charts and did not find documentation of the Lasix given for the 3 patients noted and confirmed the writing over/ changed items were not according to policy.</p>		to corresponding policies.				

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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, documentation review and interview, the facility failed to ensure the Soiled Utility room was maintained in a safe manner for staff that utilize the room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Safety Management Plan reference #1003WC indicates the physical environmental free of hazards by adhering to all local, state, and federal regulations including but not limited to OSHA, TJC, SBOH, NFPA, etc. and to manage activities proactively through risk assessment to reduce the risk of injuries.</li> <li>OSHA standard 1910.178 does not have a specific requirement for eyewash facilities; the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the</li> </ol>	S1118	<p>Eye wash station was installed in the maintenance equipment room the same day as the state inspection. To prevent this deficiency from occurring in the future, eye wash station compliance will be added to quarterly hazard surveillance checklist to ensure all departments meet OSHA regulations. David Daily, Support Services Manager, is responsible for ensuring the quarterly hazard surveillance checklist is completed and any issues corrected in a timely manner.</p>	05/01/2012			

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	<p>eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>3. At 3:00 PM on 4/30/2012, the housekeeping soiled utility room was toured. The room was observed storing soiled linen. Within the room was another room that had a large floor scrubber connected to a battery charger. At the end of the counter was a hand washing sink with one of the faucet handles missing. Above the counter were cabinets containing assorted chemicals used for floor scrubbing and waxing. The chemicals manufacture label specifies at least 15 minutes of continuous flushing of water if the eyes come in contact with the chemical. The room did not have an eye washing station that met the requirements of the chemicals and the needs of the acid from the batteries if either item would come in contact with a person's eyes.</p>						

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NAME OF PROVIDER OR SUPPLIER  HOWARD REGIONAL HEALTH SYSTEM-WEST CAMPUS SPECI	STREET ADDRESS, CITY, STATE, ZIP CODE 829 N DIXON RD KOKOMO, IN 46901
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	4. At 3:15 PM on 4/30/2012, staff member #2 indicated the batteries of the floor scrubber are routinely checked for corrosion and/or water level. The staff member indicated the wax in the cabinets would be poured in the room when needed. The staff member confirmed the Soiled Utility Room does not have an adequate eye washing station that meet the needs of a chemical or caustic splash into someone's eyes.			

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S1160	<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 observation, document review, and staff interview, the facility failed to maintain rehab step in a safe working condition and failed to ensure the Hydrocollator was maintained at the manufacturer's required temperature range.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 4/30/2012, the Rehab Department was observed with a wooden L-shape step climbing piece of equipment. The right end of the L-shape portable steps was observed with the right hand rail loose because the hand rail was able to be moved back and forth with ease. The movement of the hand rail gave the appearance the hand rail was loose and would not be secure for a patient who might lean on the hand rail while walking up the steps for rehab. Staff member #2 confirmed the hand rail seemed loose.</p> <p>2. At 2:00 PM on 5/1/2012, staff member #11 inspected the wooden steps and the</p>	S1160	<p>1. Rehab steps were inspected by Plant Operations staff. Loose bolts were tightened and a weight limit sticker was affixed to the steps. To prevent this deficiency in the futre, Plant Operations will add this piece of equipment to their quarterly hazard surveillance checklist to ensure steps are tight and in safe working condition. David Daily, Support Services Manager, is responsible for ensuring the quarterly hazard surveillance checklist is completed and any issues corrected in a timely manner.2. Hydroculator thermostat has been adjusted to meet manufacturer's temperature specification of 160-166 degrees F. To prevent this deficiency in the future, the Hydroculator temperature log was adjusted to the manufacturer's temperature specification of 160-166 degrees F. Rehab staff will check the temperature on a routine basis to ensure the equipment is operating at manufacturer specified temperature. David Kirubakaran, Clinical Services Manager, is responsible</p>	05/07/2012			

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	<p>staff member confirmed the hand rail has an unsafe appearance on how it was able to be moved. The staff member indicated the L-shape rehab steps don't have a weight limit posted on them; however, a manual had an identical piece of equipment that had a weight limit of 350 lbs. The staff member indicated he/she would be concerned if a 350 lb patient would lean against the rail for support while walking up the steps.</p> <p>3. The Hydrocollator M-2 manual stated, "Normal Operating temperature for all models was 160 F to 166 F. Never operate these units below 160 F; to do so will hasten the deterioration of the Steam Packs."</p> <p>4. The "Out pt" Department Hydrocollator Temperature Log specifies the temperature range to be between 140 and 160 F. The log noted the temperature was consistently between 156 and 160 F. The log was in conflict with what the manufacturer's manual specifies for required temperatures.</p>		for Hydrocollator temperature and completion of corresponding temperature checklist.		

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and staff interview, the facility failed to ensure 2 of 2 AEDs were daily inspected as required by the manufacturer's manual.</p> <p>Findings included:</p> <p>1. The hospital has two AEDs: Zoll and LifePak 500. Both manual were reviewed and required the same daily preventive maintenance by staff. The units are to be frequently inspected: check for green check showing that the unit is ready to use; Verify that electrodes are within their expiration date; Verify that batteries are within their expiration date; Verify that electrodes are pre-connected to the input connector; and Verify that supplies are available for use (razor, mask, gloves, extra batteries). .</p> <p>2. Nursing Use and Care of the AED policy #NURS-7 indicates the the AED will be checked daily. The daily</p>	S1168	<p>Both AED (Nursing and Sleep Department) checklists will be updated, as necessary, to reflect the items that each respective manufacturer, Zoll and Medtronic Lifepak, recommend be checked on a routine basis. Nursing and Sleep Department AED policies will be updated to reflect checklist updates. Updated checklist that corresponds with manufacturer specifications will prevent this deficiency from occurring in the future. Both AEDs will be checked daily to ensure unit is in green light status. The full AED preventive maintenance checklist will be done monthly in the Sleep Center and daily in Nursing. Claudia Lowry, Director of Nursing, and Jennifer Delvecchio, Sleep Center Manager, are responsible for ensuring daily and monthly checking of AEDs is done and all items are checked as recommended by respective AED manufacturer.</p>	05/25/2012

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	<p>inspection only requires checking the AED light for being on.</p> <p>3. The two daily Crash Cart Checklist were reviewed. The Nursing Unit utilizes the LifePak 500 while the Sleep Lab Department has the Zoll. Both logs are identical and only specify AED Battery Check.</p> <p>4. At 3:15 PM on 5/1/2012. staff member #1 indicated the Nursing Unit and the Sleep Lab only check the batteries and do not check the other items listed in the operation manuals.</p>			