

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150088		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER ST VINCENT ANDERSON REGIONAL HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2015 JACKSON ST ANDERSON, IN 46016			
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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005078</p> <p>Survey Date: 8-05-13 to 8-07-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Steve Poore, BS MLT Medical Surveyor 3</p> <p>QA: claughlin 08/19/13</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 personnel file review, document review, and interview, the facility failed to ensure that state rules and regulations were complied with in reference to IC 16-28-13 for one SNT (student nurse tech-N10) and one MTT (multi task tech-N11)</p> <p>Findings:</p> <p>1. at 1:35 PM on 8/7/13, a review of IC 16-28-13-4, with staff member #51, the director of quality, indicated that:</p> <p>a. "Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or (2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for 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 10-13-3 or another</p>	S000102	<p>8/7/13 Upon identification that the "Indiana Online Licensing Nurse Aide Registry" check had not been completed for the MTT the "Indiana Online Licensing Nurse Aide Registry" was accessed and it was verified that the MTT did have a current Certified Nurse Aide License with no previous action related to this license. 9/9/13 It was determined this omission of checking the "Indiana Online Licensing Nurse Aide Registry" at time of hire was due to the Human Resources associate completing the "New Hire Checklist" was not aware that the State Nurse Aide Registry check applied to the MTT job classification. The "New Hire Checklist" has been revised by the Recruiter to include the job classification titles (PCT, MTT, MHAA, and SNT) that require checking of the "Indiana Online Licensing Nurse Aide Registry" at the time of hire. Human Resources associates educated on revisions to the "New Hire Checklist".</p>	09/09/2013			

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	<p>source by law."</p> <p>2. review of the policy and procedure "Requirements for Employment - HR-216", with a last revised date of 10/2010, indicated:</p> <p>a. under "Action Steps...", on page two, it reads: "...4. St. Vincent Anderson will perform such additional background checks and follow any additional hiring procedures regarding individuals for particular jobs as may be required by law or St. Vincent Anderson..."</p> <p>3. at 2:20 PM on 8/7/13, review of the document "New Hire Checklist", indicated that human resources checks "EMT (emergency medical technology) or Indiana State Nurse Aide registry" for newly hired personnel</p> <p>4. review of employee personnel files indicated:</p> <p>a. staff member N10, a SNT was hired 5/14/12 and lacked documentation of a check with the state nurse aide registry</p> <p>b. staff member N11 was a MTT hired 9/26/11 who lacked documentation of a check with the state nurse aide registry</p> <p>5. interview with staff member #51, the director of quality, at 2:20 PM on 8/7/13 indicated:</p> <p>a. staff members N10 and N11 have</p>		<p>9/9/13 In review of SNT file (Angel Alter) by a Human Resources associate, Recruiter, documentation that the "Indiana Online Licensing Nurse Aide Registry" check was completed on 3/29/12 was found. The results of the search returned no findings. An SNT is not required to be a Certified Nursing Assistant per St. Vincent Anderson Regional Hospital policy. Documentation of this compliance can be provided to ISDH upon request. Title of person responsible for follow up: Recruiter, Human Resources associate</p>	

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	<p>duties that require them to have hands on patient care and other duties such as a nurse aide might perform</p> <p>b. the human resources department indicated MTTs and SNTs are two of the many job titles that require a check of the nurse aide registry</p> <p>c. after checking with human resources, it was found that no nurse aide registry check was done for staff members N10 and N11, as is expected to be accomplished for these job titles, at the time of hire</p>			

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S000178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and interview, the facility failed to post a copy of its current license in a conspicuous area open to patients and public for 4 of 5 locations operated under the hospital license.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a tour on 8-05-13 at 1145 hours, lack of a posted license was observed in the common public area of the main entrance reception and waiting area of the facility. 2. During an interview on 8-05-13 at 1145 hours, staff A6 confirmed the hospital license was not on display in the main entrance area of the building. 3. During a tour on 8-06-13, lack of a posted license was observed in the common public areas of the following outpatient services located in the Erskine medical office building: 	S000178	<p>8/6/13 a copy of the 2013 hospital license was emailed by the VP of Operations to the managers/directors of all areas with request to validate that current license was posted in the off-site departments. 8/16/13 Director of Quality/Risk Management and Regulatory Readiness validated that current license is posted at the following sites: Main entrance reception Radiation Oncology Suite Erskine Rehabilitation Suite Chemotherapy Infusion Suite All other off-site locations Annually, a copy of the hospital license will be distributed and posted to all off-site locations and in the main entrance. Director of Quality/Risk Management and Regulatory Readiness will validate that new license posted in all off-site areas and the main entrance by 1/6/14. Title of person responsible for follow up: Director, Quality/Risk Management and Regulatory Readiness</p>	08/16/2013			

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	<p>a. radiation oncology suite at 1050 hours</p> <p>b. Erskine Rehabilitation suite at 1130 hours</p> <p>c. chemotherapy infusion suite at 1145 hours</p> <p>4. During an interview on 8-06-13 at 1205 hours, staff A14 confirmed the radiation oncology suite lacked a posted license.</p> <p>5. During an interview on 8-06-13 at 1130 hours, staff A6 confirmed the outpatient rehabilitation suite lacked a posted license.</p> <p>6. During an interview on 8-06-13 at 1145 hours, staff A6 confirmed the chemotherapy infusion suite lacked a posted license.</p>				

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S000320	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(G)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee. Based on review of policy/procedure and staff interview, the governing board failed to ensure a post offer physical for 2 of 8 staff members reviewed.</p> <p>Findings include:</p> <p>1). On 08/06/13 between 2:30 pm and 4:00 pm, review of policy titled; "St Vincent Health...Post-Offer Physical Assessment...Policy Number AH-05...Effective Date: 10/6/10 POLICY STATEMENT:..." states the following: "A post offer physical assessment is given to each prospective associate prior to assuming job responsibilities..."</p> <p>2). In interview on 08/05/13 at 3:45 pm, staff member SP-5, confirmed there was no post offer physical documentation available for his/her file.</p>	S000320	9/9/13 The Director of Quality/Risk Management and Regulatory Readiness to educate staff at next Regulatory Readiness Meeting (scheduled for September 25,2013) on the content of the "Manger's Checklist for Contract Labor" which includes the need for a physical exam. Staff education to managers/directors responsible for contract staff will include need to have contract staff file reviewed by the Associate Health nurse for completeness. 9/9/13 Compliance with "Post Offer Physical Assessment Policy" added to the Contract Vendor Evaluation List (with performance improvement indicators) for contracted services with St. Vincent Anderson Regional Hospital. The Contract Vendor List will be reviewed by Performance Improvement Committee and the Governing	09/25/2013			

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	3). In interview on 08/06/13 at 2:45 pm, staff member SP-4, confirmed there was no post offer physical documentation available for his/her file.		Board. Title of person responsible for follow up: Director, Quality/Risk Management and Regulatory Readiness		

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S000394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 10 of 56 contracted services.</p> <p>Findings:</p> <p>1. On 8-05-13 at 1600 hours, a list of all contracted services was received from staff A3. The list of services failed to indicate a service provider for air exchange testing, exhaust hood certification, 4 fire prevention services, generators, medical gas manifold certification, pest control and vacuum pumps.</p> <p>2. Review of facility documentation indicated the following: air exchange testing by CS1, exhaust hood certification by CS2, fire service providers included CS3, CS4, CS5 and fire panel monitoring</p>	S000394	<p>8/15/13 A comprehensive list of contracted services has been updated to include, but not limited to, the following service providers: Air exchange testing—completed every 3 years by Total Balance (Reviewed during Annual Survey with no findings stated) Exhaust hood certification—Pharmacy:Containment Technology Group; Laboratory: TriMedex Cancer Center: TriMedex Fire prevention services—Seimens, Koorsen, and Grunau Fire Panel monitoring—completed daily by Engineering associates in the Boiler room and quarterly by Seimens Generators--McCallister Medical gas manifold certification—Quintech and Artec Pest control--Terminix Vacuum pumps--Quintech Performance measures have been established by the respective department Director/Vice President for ongoing quarterly monitoring of services provided. The</p>	08/15/2013	

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	<p>by CS6, generator service by CS7, medical gas manifold certification by CS8, pest control service by CS9 and vacuum pump service by CS10.</p> <p>3. On 8-07-13 at 0930 hours, staff A2 confirmed the list of contracted services failed to include the indicated service providers.</p>		<p>performance measures will be reported to Performance Improvement Committee quarterly and to the Governing Board annually. Title of person responsible for follow up: Director, Quality/Risk Management and Regulatory Readiness</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 interview, the performance improvement (PI) program lacked documentation indicating that all services including contracted services were evaluated and reviewed for 4 direct and 18 contracted services.</p> <p>Findings:</p> <p>1. The Performance Improvement and Patient Safety Plan for Calendar Year 2013 (approved 11-12) lacked a provision for monitoring, evaluating, and reporting contracted services provided at the facility.</p> <p>2. On 8-05-13 at 1115 hours, staff A2 and A3 were requested to provide documentation indicating that all services including contracted services were</p>	S000406	8/15/13 The comprehensive list of contracted services has been updated to include, but not limited to, the service providers listed below. Performance measures have been established by the respective department Director/Vice President for ongoing quarterly monitoring of services provided. The performance measures will be reported to Performance Improvement Committee quarterly and to the Governing Board annually. Partial listing of service providers: Cardiac Cath Lab--Toshiba Laundry--Not a contracted service Diagnostic Radiology--Northwest Radiology Respiratory Therapy--Not a contracted service Air Exchange Testing--completed every 3 years by Total Balance Dietary-Touchpoint Elevators--Otis Elevator Company Environmental	08/15/2013	

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	<p>evaluated and reported through the PI program and none was provided prior to exit.</p> <p>3. The 2013 PI committee minutes failed to indicate that the direct services of cardiac cath lab, laundry, diagnostic radiology and respiratory therapy were evaluated and reviewed and failed to indicate that the contracted services of air exchange testing, dietary, elevators, environmental services, exhaust hood certification, 4 fire prevention providers, generators, hemodialysis, laboratory, medical gas manifold certification, pathology, pest control, PET/CT imaging, vacuum pumps and valet parking services were reviewed.</p> <p>4. During an interview on 8-07-13 at 0920 hours, staff A2 indicated that the facility has not been reviewing indirect patient contracted services through the PI program.</p> <p>5. During an interview on 8-07-13 at 1220 hours, staff A3 confirmed that the PI department scorecards were not being reviewed through the PI program and confirmed that the PI committee minutes lacked documentation indicating all services including contracted services were evaluated and reviewed through the PI program.</p>		<p>Services--Touchpoint Exhaust hood certification—Pharmacy:Containment Technology Group; Laboratory: TriMedex Cancer Center: TriMedex Fire Prevention providers—Seimens, Koorsen and Grunau Generators- -McCallister Hemodialysis—Fresenius Dialysis Laboratory—Central Indiana Regional Blood Center and Mid-America Clinical Laboratories Medical Gas Manifold Certification—Quintech and Artec Pathology—Ameripath Pathology Services Pest Control--Terminix PET/CT Imaging—Northwest Radiology and Alliance Imaging, Inc Vacuum Pumps--Quintech Valet Parking Services—Towne ParkTitle of person responsible for follow up: Director, Quality, Risk Management anf Regulatory Readiness</p>				

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S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(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>(i) Sanitation. Based on document review and interview, the infection control (IC) committee failed to document review and approval of housekeeping policies for cleaning and disinfecting in the restricted operating room (OR) areas by contracted service personnel .</p> <p>Findings:</p> <p>1. The Infection Prevention Plan 2013 (approved 5-13) indicated the following: " [The] committee monitors aseptic techniques used in operating rooms, birthing center, nurseries and patient treatment areas and recommend improvements ... "</p> <p>2. The facility environmental services</p>	S000592	9/9/13 SVARH "Surgery Daily and Periodic Cleaning Policy" revised by Director of Environmental Services to reflect step-by-step process for cleaning and disinfecting the restricted surgical areas. 9/12/13 SVARH "Surgery Daily and Periodic Cleaning Policy" and "Surgical Areas Cleaning Policy" reviewed by the Infection Control Practitioner and submitted to P&T Committee (Medical Staff By-laws state the P&T Committee shall be responsible for infection control functions) for review and approval. The Infection Control Plan designates the P&T Committee as the oversight committee for infection control practices. Title of person responsible for follow up: Infection Control Practitioner	09/12/2013	

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	<p>policy/procedure SJMC Surgery Daily & Periodic Cleaning (revised 10-12) failed to indicate a process for cleaning and disinfecting the restricted surgical areas and lacked documentation of IC committee review and approval.</p> <p>3. The contracted environmental services policy/procedure Surgical Areas Cleaning (approved 10-12) lacked documentation of IC committee review and approval for use by contracted personnel when performing the terminal OR cleaning and disinfecting at the facility.</p> <p>4. During an interview on 8-06-13 at 1625 hours, staff A5 confirmed that the contracted service and facility surgical cleaning policy/procedures lacked documentation of IC committee review and approval.</p>				

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S000594	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ii)</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>(ii) Universal precautions, including infectious waste management.</p> <p>Based on document review, observation and interview, the infection control (IC) committee failed to document review and approval of environmental services policies for infectious waste management and ensure that handling and disposal of medical waste was performed in compliance with State law and accepted standards of practice.</p> <p>Findings:</p> <p>1. The Centers for Disease Control and Prevention (CDC) Guidelines for Environmental Infection Control in Health Care Facilities (2003) indicated the following: " Any facility that generates regulated medical wastes should have a regulated medical waste plan to</p>	S000594	<p>8/5/13 When the Manger, Environmental Services, became aware of the 31 bottles filled with liquid pathological waste/body fluids he properly disposed of the bottled content by flushing it down the septic system while wearing appropriate personal protective equipment. 8/23/13 Environmental Services "Waste Management Policy" was revised to comply with the CDC Guidelines and Indiana Code related to provisions for handling and disposal of pathological waste/body fluids in liquid or semi-liquid form. The receptacle containing infectious waste will be placed in a red bag and disposed of in red bag trash. The red bag trash is processed in the sterilizer, under pressure, for one hour. The infectious waste is</p>	09/12/2013			

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	<p>ensure health and environmental safety ... [and] ...the contents of all vessels that contain more than a few milliliters of blood remaining after laboratory procedures, suction fluids, or bulk blood can either be inactivated in accordance with state-approved treatment technologies or carefully poured down a utility sink drain or toilet... "</p> <p>2. Indiana Code (IC) 16-41-16 Communicable Disease: Treatment of Infectious Waste (2013) indicated the following: " ...the term [infectious waste] ...includes [pathological waste] ...includes blood or body fluids in liquid or semi-liquid form ...[and] ...before infectious waste is ...sent for final disposal, all infectious waste must be effectively treated on site or transported off site for effective treatment ...effective treatment means treatment that ...reduces the pathogenic qualities of infectious waste to a point where the waste is safe to handle [and] is designed for the specific waste involved ...[or] ...flush the liquid waste or excreta that are infectious waste in compliance with rules adopted under IC 4-22-2 ... "</p> <p>3. The environmental services policy/procedure Waste Management (revised 4-13) failed to indicate a provision for handling and disposal of</p>		<p>converted to non-infectious waste and the liquid is disposed of via the septic system. These receptacles are no longer stored in the non-biohazard labeled room. They are disposed of as they are generated. 9/12/13 "Waste Management Policy" reviewed by the Infection Control Practitioner and approved by the P&T Committee. Associates trained on revisions to the policy by the Infection Control Practitioner and departmental Educators. Title of person responsible for follow up: Infection Control Practitioner</p>	

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	<p>pathological waste/body fluids in liquid or semi-liquid form and lacked documentation of IC committee review and approval.</p> <p>4. During a tour on 08-05-13 at 1400 hours, the following condition was observed in the main environmental services department: an unlabeled and unsecured metal cabinet containing 31 closed 500 milliliter bottles filled with liquid pathological waste/body fluids. A majority of containers contained pale yellow transparent liquid of unknown origin and 5 bottles contained clear to opaque red-colored liquid.</p> <p>5. During an interview on 8-05-13 at 1415 hours, housekeeping manager A8 indicated that environmental services staff were disposing of the pathological waste by emptying the containers into a floor drain in the center of the room and staff A8 indicated that they (A8) did not know the source of the waste containers awaiting disposal.</p> <p>6. During an interview on 8-06-13 at 0950 hours, staff A8 confirmed that the waste management policy/procedure lacked a provision for handling and disposal of pathological waste in accordance with State law and CDC Guidelines.</p>			

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	7. During an interview on 8-06-13 at 1615 hours, the IC nurse A5 confirmed that the waste management policy/procedure lacked a provision for handling and disposal of pathological waste and lacked documentation of IC committee review and approval.			

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S000606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on review of policy/procedure and staff interview, the infection control committee failed to ensure an employee health program that determines the communicable disease history, for 1 of 8 staff members reviewed.</p> <p>Findings include:</p> <p>1). On 08/06/13 between 2:30 pm and 4:00 pm, review of policy titled; "St. Vincent Anderson Regional Hospital...Contract Labor--Non-nursing Departments-HR-242..." states the following: "...Contract labor individuals will meet the same employment requirements as St. Vincent Anderson</p>	S000606	9/9/13 Associate Health Nurse reviewed file of staff member cited for lack of documentation of Rubella, Rubeola and Varicella. No documentation found. Associate Health Nurse arranged for this staff member to have titers drawn and physical to be completed. Associate Health Nurse to review titers and complete appropriate follow up. 9/9/13 The Director of Quality/Risk Management and Regulatory Readiness to educate staff at next Regulatory Readiness Meeting (scheduled for September 25,2013) on the content of the "Manger's Checklist for Contract Labor" which includes the need for screening for communicable	09/09/2013			

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	<p>associates...Proof of immunity to measles, rubella and mumps...Proof of immunity to varicella (chicken pox)..." (Effective date: 08/1991, Approved date: 03/2013).</p> <p>2). In interview on 08/06/13 at 2:45 pm, staff member SP-4, confirmed there was no immunization documentation available in his/her file for Rubella, Rubeola, and Varicella.</p>		<p>disease. Staff education will include manager/director responsible for contract staff to have contract staff file reviewed by the Associate Health nurse for completeness. Title of person responsible for follow up: Associate Health Nurse</p>		

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S000726	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following:</p> <p>(A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based on observation, document review and interview, the facility failed to ensure the confidentiality of patient medical records in one off site toured (the Brown Street Women's Clinic and Coumadin Clinic) and failed to follow their policy/procedure ensuring that medical records (MR) were not accessible to unauthorized individuals in one area toured (day surgery).</p> <p>Findings: 1. at 9:30 AM on 8/7/13, while on tour of the Brown Street Women's Clinic and Coumadin Clinic, in the company of staff</p>	S000726	8/7/13 Secured file cabinet ordered by Manager, Pharmacy, to be utilized in the Coumadin Clinic to secure Coumadin Clinic charts. 9/3/13 New file cabinet received but file cabinet damaged during shipping. File cabinet returned to vendor. To be replaced in next 7-10 days per Pharmacy Manager. Staff educated by Pharmacy Manager on need to have all medical records secured when staff not present in the area. 8/7/13 Secured file cabinet obtained by Director, Surgical Services, for the Day Surgery area. Secured file cabinet in place and medical	09/16/2013			

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	<p>members #51, the director of quality, and #62, the OB manager and supervisor of the clinic, it was observed that patient medical records are located in the reception area on a rolling cart and not secured after hours</p> <p>2. at 9:30 AM on 8/7/13, interview with staff members #51 and #62, indicated:</p> <p>a. patient medical records for both the women's clinic and the coumadin clinic are located in the same central reception area</p> <p>b. housekeeping staff have access to patient medical records after hours</p> <p>c. medical records are not locked in a cabinet at the end of the work day, but are accessible in the reception area</p> <p>3. The policy/procedure Security of Medical Records (revised 08-11) indicated the following: " Confidentiality will be maintained by limiting access to authorized personnel. "</p> <p>4. During a tour of the day surgery on 8-05-13 at 1150 hours, MR were observed in an open-top, wheeled chart rack located adjacent to the nursing station counter. Staff A17 indicated that the rack containing patient records for the next day procedures was stored overnight under the counter and environmental services staff cleaned the unit at night when department staff were not present.</p>		<p>records secured when surgery staff not present in the area. Director of Surgical Services reviewed with staff need to secure medical records in locked cabinet whenever staff not present and always at the end of the day. Title of person responsible for follow up: Manager, Pharmacy</p>		

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	5. During an interview on 8-06-13 at 1220 hours, staff A11 confirmed that the MR prepared for the day ahead were not stored in a locked drawer or cabinet overnight when environmental services staff were present.			

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the chief nursing officer failed to ensure the implementation of the pain policy for 2 of 2 open patient records on</p>	S000912	9/9/13 Nursing Unit managers to re-educate all nurses on "Pain Management Policy" requirement to reassess response to pain interventions within 60 minutes during his/her annual	09/30/2013

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	<p>the 3 south nursing unit (pts. #3 and #4).</p> <p>Findings:</p> <p>1. at 3:55 PM on 8/5/13, review of the policy and procedure "Pain Management -ADMIN-197", with a last revised date of 02/2011, indicated:</p> <p>a. under "Action Steps", it reads: "...2. Assess and reassess as appropriate pain and the response to pain management interventions within 60 minutes using the most appropriate assessment tool based on established verbal and/or nonverbal patient reports..."</p> <p>2. review of open patient medical records while touring the 3 south general surgery and joint replacement nursing units indicated:</p> <p>a. pt. #3:</p> <p>A. was given Norco two tables at 8:38 AM on 8/4/13 with a re assessment at 10:03 AM</p> <p>B. was given Norco two tablets at 3:56 PM on 8/4/13 and had a re assessment at 6:03 PM</p> <p>b. pt. #4:</p> <p>A. was given Dilaudid 1 mg per IV (intravenous) route at 7:19 AM on 8/5/13 with a re assessment at 9:00 AM</p> <p>B. was given Dilaudid 1 mg IV at 9:26 AM on 8/5/13 with a re assessment at 11:45 AM</p>		<p>performance evaluation to be completed by 9/30/13. Nursing unit managers to complete quarterly chart review on 5 charts/nurse for the next 12 months assessing that the pain reassessment was completed within 60 minutes of administration of pain medication. Nursing manager to provide ongoing feedback to each nurse and take corrective action, if indicated. Title of person responsible for follow up: Director, Inpatient Nursing</p>		

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	<p>C. was given Dilaudid 1 mg IV at 11:47 AM on 8/5/13 with a re assessment at 1:52 PM</p> <p>3. interview with staff member #57, the 3 south nursing manager, while reviewing the medical records on line, indicated:</p> <p>a. there was no documentation in the nursing notes section of the medical records that indicated re assessment occurred within the 60 minutes required per policy related to the administration of pain medications for pts. #3 and #4, as written in 2. above</p> <p>b. the pain re assessments for patients #3 and #4 were not per policy requirements</p>			

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S001118	<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 policy and procedure review, document review, observation, and interview, the facility failed to ensure that no condition would be created that might result in a hazard to patients related to: glucometer control solutions not dated when opened; dusty blanket warmers; dirty refrigerators; expired products; and one bathroom nurse call chord.</p> <p>Findings:</p> <p>1. at 8:15 AM on 8/6/13, review of the policy and procedure "ACCU-Chek Inform Meter - NUR-213", with a last revised date of 4/2013, indicated:</p> <p>a. on page 2, under "Acquisition of ...supplies", it reads: "B. Action Steps...1. The laboratory will retain the responsibility of maintaining glucose meter supplies at the point-of-care testing site..."</p> <p>b. the policy lacks indication that the</p>	S001118	<p>Glucometer 8/5/13 Open Glucometer control solutions were discarded by the 3 South manager when it was identified that no expiration date had been noted on the open control solutions. 9/6/13 "Accu-Check Inform Meter—Nur 213" revised by Chief Nursing Officer to indicate that the control solutions expire 90 days after opening. Both the expiration date and date opened will be noted on the control solution when initially opened. Director of Inpatient Nursing to develop and implement a Glucometer Control monthly checklist to be used to validate that current opened glucometer control solution is dated and has not expired. 9/25/13 Director of Quality/Risk Management and Regulatory Readiness to distribute Glucometer Control monthly checklist at the Regulatory Readiness meeting for use by all</p>	09/25/2013	

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	<p>control solutions expire 90 days after opening</p> <p>2. at 1:10 PM on 8/6/13, review of the document "Whole Blood Glucose Accu-Chek Inform Glucose Monitoring System" provided by lab personnel, indicated:</p> <p>a. under the section "Reagent Storage and Handling", it reads: "...Accu-Chek Comfort Curve Glucose control solutions-Level 1 (LO), Level 2 (HI)...The glucose control solutions are stable 3 months after opening the bottles or until the expiration date, whichever comes first..."</p> <p>3. at 2:37 PM on 8/5/13, while on tour of the third floor south general surgery and joint replacement nursing unit in the company of staff member #51, the quality director, and #57, the 3 south manager, it was observed that:</p> <p>a. one set of the accu chek inform control solutions (both HI and LO vials) had no notation of date opened or date of expiration, making it impossible to determine when the 90 day expiration date is, or was</p> <p>b. one set of the accu chek inform control solutions (both HI and LO vials) had smeared dates written on the vials for both the date opened and the 90 day expiration date, making it impossible to</p>		<p>areas performing accuchecks. Blanket warmers: 8/20/13 Blanket Warmer temperature log updated by the Director of Quality/Risk Management and Regulatory Readiness to include a check of the cleanliness of the blanket warmer daily at the same time as the temperature check. This was reviewed at the Regulatory Readiness Team meeting by the Director of Quality/Risk Management and Regulatory Readiness. 9/12/13 Blanket/Fluid Warmer Policy" revised by Director of Inpatient Nursing to include that the cleanliness of the blanket warmer is the responsibility of the Manager. 8/20/13 Weekly cleaning of the Code Carts assigned to the appropriate staff by nursing unit managers. Nursing Unit managers are responsible for ensuring that patient care equipment is properly cleaned. Refrigerator 8/5/13 Bennett Rehab refrigerator was cleaned and food items without labeled/date were discarded under the supervision of the unit manager. Daily cleaning of the refrigerator has been assigned to the Bennett Rehab MTT's by the unit manager. 8/5/13 3 South and Critical Care/Progressive refrigerators were cleaned under the supervision of the unit managers. The unit managers have incorporated daily cleaning of the refrigerators into the daily temperature check and added</p>				

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	<p>determine when the 90 day expiration date is, or was</p> <p>c. a note was taped to the lid of the case for the control solutions indicating that nursing staff were to note on the control solutions both the date opened and the 90 day discard date</p> <p>4. interview with staff members #51 and #57 at 2:40 PM on 8/5/13 indicated the control solutions were not labeled as per instructions on the control solutions case and per manufacturer's recommendation</p> <p>5. at 9:00 AM on 8/6/13, review of the policy and procedure "Blanket/Fluid Warmer - SS-241", with a last date revised of 01/2012, indicated there is nothing in the policy related to the routine cleaning of the warmers</p> <p>6. at 1:20 PM on 8/5/13, while on tour of the critical care unit/progressive unit in the company of staff members #51, the quality director, and # 56, the unit manager, it was observed that:</p> <p>a. the top shelf and bottom black bar surrounding the code cart were dusty</p> <p>b. the Amsco blanket warmer in the clean utility room had a large accumulation of dust under the plenum shelf (lower slotted shelf) of the top cabinet</p>		<p>weekly through cleaning of the refrigerators. 8/12/13 Director, Engineering Services, revised monthly Environment of Care Rounds form to include checking the cleanliness of the associate refrigerator as part of the assigned Environment of Care rounds. 8/25/13 The Director of Quality/Risk Management and Regulatory Readiness reviewed at the monthly Regulatory Readiness Team meeting the need for department managers to ensure that patient care and associate refrigerators are clean. The Director, Quality/Risk Management and Regulatory Readiness distributed the "Patient Care and Associate Refrigerator Temperature/Clean Log" to all department managers/directors. 9/26/13 The Director of Quality/Risk Management and Regulatory Readiness to compile a list of all patient refrigerators, associate refrigerators and blanket warmers for periodic safety checks by assigned managers/directors. Reporting of findings will be to the monthly Regulatory Readiness Team or at Daily Huddle meeting. The findings of the rounding will be shared with the Infection Control Practitioner for review by the Infection Control Committee and action to be taken as needed to maintain cleanliness of all refrigerators and blanket warmers. 8/6/13 Expired supplies--the code cart was</p>		

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	<p>7. at 1:20 PM on 8/5/13, interview with staff members #51 and #56 at 1:20 PM indicated agreement that the code cart and blanket warmer were dusty and were not on a routine cleaning schedule</p> <p>8. at 2:25 PM on 8/5/13, while on tour of the third floor south general surgery and joint replacement nursing unit in the company of staff member #51, the quality director, and #57, the 3 south manager, it was observed in the clean utility room that:</p> <p>a. the Amsco blanket warmer had a large accumulation of dust under the plenum shelf (lower slotted shelf) of the top cabinet</p> <p>b. there was an accumulation of dust around the bottom of the code cart</p> <p>9. at 2:25 PM on 8/5/13, interview with staff members #51 and #57 indicated there was dust present as stated in 8. above and that there was no scheduled cleaning of either item</p> <p>10. at 8:15 AM on 8/6/13, review of the policy and procedure "Refrigerator Monitoring - ADMIN-191" with a last date revised of 02/2011, indicated:</p> <p>a. on page one under "Definition", it reads: "...7. Ensuring that a system is in place to guarantee cleanliness/temperature of the refrigerator is the responsibility of</p>		<p>removed form service and all supplies checked for outdated supplies and stocked to established list of content for code carts in operating room. Central Supply Manager verified that it is the responsibility of the Central Supply staff to check the code cart for outdates and that this code cart is on the departmental list of items to check for outdates quarterly. 8/6/13 Nurse call light cord was untied from the hand rail and adjusted to an appropriate length by the Surgery Center DirectorTitle of person responsible for follow up: Director, Quality, Risk Management and Regulatory Readiness</p>	

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	<p>the Manager..."</p> <p>b. on page two under "Patient Food Refrigerators...12. Discourage patients from bringing food items in from outside the hospital for refrigerated storage. If such items are brought in, they must be labeled, dated, and discarded in the same manner as hospital supplied food."</p> <p>11. at 2:00 PM on 8/5/13, while on tour of the Bennett Rehab nursing unit in the company of staff members #51, the director of quality, and #67, the nurse manager of the unit, it was observed that:</p> <p>a. the patient food refrigerator was dirty on the shelf atop the vegetable drawers</p> <p>b. the vegetable drawers were dirty</p> <p>c. there were two items brought from home in the freezer that were not labeled and dated as required by policy (it was undetermined if these items were staff or patient food items)</p> <p>12. interview at 2:00 PM on 8/5/13 with staff member #67 indicated refrigerators are cleaned only "when needed" and not on a routine cleaning schedule</p> <p>13. at 2:30 PM on 8/5/13, while on tour of the third floor south general surgery and joint replacement nursing unit in the company of staff member #51, the quality director, and #57, the 3 south manager, it was observed that the patient refrigerator</p>						

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	<p>had:</p> <ul style="list-style-type: none"> a. a sticky substance on the seal of the freezer, and freezer door, making the freezer door hard to open b. crumbs on the top shelf of the refrigerator c. a dried pool of liquid substance (resembled milk) under the vegetable drawers <p>14. at 2:30 PM on 8/5/13, interview with staff member #57 indicated there is no routine cleaning schedule for the refrigerator</p> <p>15. at 1:30 PM on 8/5/13, while on tour of the critical care/progressive care area in the company of staff members # 51, the director of quality, and #56, the manager of the unit, it was observed that the top of the staff and patient refrigerators in the pantry area had a large accumulation of dust on the top of each appliance</p> <p>16. review of the policy and procedure "Outdating Manufacturer's Sterilized Materials", code 7044-50-9C, with a last reviewed/revised date of 8/13, indicated:</p> <ul style="list-style-type: none"> a. under "Definition", it reads: "Manufacturer's supplies are checked monthly for outdated materials. Any outdated materials will be checked throughout areas of the facility serviced by the Central Supply Department." 						

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	<p>17. on 8/6/13 at 10:47 AM, while on tour of the main surgery department in the company of staff member #59, the surgery manager, it was observed in the code cart that:</p> <ul style="list-style-type: none"> a. one Arrow Multi lumen CVC kit expired 5/13 b. one Arrow Highflow fluid Blood filter administration kit expired 6/13 <p>18. interview with staff member #59 at 10:47 AM on 8/6/13 indicated:</p> <ul style="list-style-type: none"> a. the Arrow kits were expired as noted in 17. above b. the "supply chain" staff (from central sterile) are responsible for monthly checks of supplies for expiration dates <p>19. at 9:20 AM on 8/6/13, while on tour of the off site surgery center in the company of staff members #51, the quality director, and #58, the outpatient surgery director, it was observed that the patient bathroom in the pre op area had the nurse call light chord wrapped around the hand railing</p>			

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S001168	<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, observation and interview, the hospital failed to ensure that defibrillator inspection and testing was performed according to the manufacturer's recommendations at the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> The facility Physio-Control LifePak 20 Operating Instructions (2007 edition) Appendix D indicated the Operator ' s Checklist of manufacturer's recommendations for daily inspection and testing of the defibrillator. The policy/procedure Lifepak 20 Monitor/Defibrillator/AED (approved 11-10) lacked a provision indicating that the defibrillator will be discharged at least in accordance with the manufacturer ' s recommendations. During a tour of the Emergency 	S001168	<p>9/11/13 "Life Pak 20 Monitor/Defibrillator/AED policy" revised by, Director, Inpatient Nursing to reflect manufacturer's Operator's Checklist, including discharging of the defibrillator. Checklist to be implemented with checks to be completed every shift that the department is open for patient care. Associates educated by departmental Educator in policy changes including discharging of the defibrillator. 9/25/13 the Director of Quality/Risk Management and Regulatory Readiness to distribute at the monthly Regulatory Readiness Team meeting the revised "Life Pak 20 Monitor/Defibrillator/AED Policy" and educate manager/director on need for implementation in all areas with this type of equipment. Title of person responsible for follow up: Director, Inpatient Nursing</p>	09/25/2013	

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	<p>Department (ED) on 8-06-13 at 1210 hours, a Lifepak 20 monitor/defibrillator was observed in the main hall adjacent to the nursing station. The document Code Cart - Lifepak 20 front Checklist/Log located on top of the Code Cart failed to indicate that the defibrillator checks were performed in accordance with the manufacturer ' s recommendations and failed to indicate or incorporate the additional checks listed on the Operators Checklist in appendix D.</p> <p>4. During an interview on 8-05-13 at 1210 hours, staff A16 confirmed that the ED Code Cart Checklist/log failed to ensure that the Lifepak 20 defibrillator was checked in accordance with manufacturer ' s recommendations.</p> <p>5. Documentation indicated that Lifepak 12, Lifepak 20, Zoll Model M and Zoll PD 1400 defibrillators were currently in use at the facility. On 8-06-13 at 0925 hours, staff A10 was requested to provide documentation indicating that facility defibrillators were being inspected and tested in accordance with manufacturer ' s recommendations and none was provided prior to exit.</p> <p>6. During an interview on 8-06-13 at 1235 hours, staff A2 confirmed that the facility lacked documentation that</p>						

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	defibrillator checks were being performed per manufacturer ' s recommendations.			

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S001318	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C)(D)(E)(F)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and</p> <p>Based on policy and procedure review, transfer patient medical record review, and interview, the facility failed to implement its policy related to patients transferred from nursing units to other acute care facilities for 2 of 3 patients (patients # 9 and #11).</p> <p>Findings: 1. at 2:00 PM on 8/7/13, review of the policy and procedure "Patient Transfers - ADMIN-168", with a last revised date of 05/2013, indicated:</p>	S001318	9/9/13 Director, Inpatient Nursing, to provide re-education to inpatient nursing staff via monthly newsletter the need to complete the "Emergency Transfer Summary" note via the electronic medical record and request that the transferring physician complete the "Physician's Certificate of Transfer" at the time of ordering the transfer to another acute care facility. 9/11/13 Manager, Quality/Risk Management, to review daily "Admission/Discharge/Transfer" list to identify any patients	09/30/2013			

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	<p>a. on page 5 under "When to Utilize Specific Forms:", it reads: "...B. Medically appropriate non-emergency transfer from any patient area of St. Vincent Anderson to another acute care facility: 1. emergency Medical Condition Transfer Form...2. Emergency Transfer Summary Form...(used only during computer downtime)..."</p> <p>2. at 11:35 AM on 8/7/13, review of 3 patient medical records transferred from nursing units to other acute care facilities indicated:</p> <p>a. pt. #9 was transferred on 7/23/13 and lacked a transfer form in the medical record</p> <p>b. pt. #11 was transferred on 7/18/13 and lacked a transfer form in the medical record</p> <p>3. at 2:00 PM on 8/7/13, interview with staff member #51, the quality director, indicated:</p> <p>a. HIM (health information management staff) confirmed that the medical records for patients #9 and #11 are lacking transfer forms/documents, as required per facility policy</p>		<p>transferred to another acute care facility. All identified cases will be reviewed for presence of electronic completion of the "Emergency Transfer Summary" note and a hard copy of the "Physician's Certificate of Transfer". Manager, Quality/Risk Management will provide ongoing feedback to Director, Inpatient Nursing, of this chart audit. Title of person responsible for follow up: Manager, Quality/Risk Management</p>				