

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152026	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2013
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NAME OF PROVIDER OR SUPPLIER RIVERCREST SPECIALTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1625 E JEFFERSON BLVD MISHAWAKA, IN 46545
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 02/5/2013 through 02/06/13</p> <p>Facility Number: 012130</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 02/13/13</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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S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</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:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on documentation review and staff interview, the facility failed to ensure policies and procedures were updated to current practices for 4 policies that were reviewed.</p> <p>Findings included:</p> <p>1. Hot Packs policy II-E.28 (last approved date 2/12) states, "Check hydrocollator temperature (temperature should between 155 to 165 degrees)."</p> <p>2. At 2:15 PM on 2/5/2013, staff member #10 indicated the manufacturer's recommendations</p>	S000322	<p>1. Hot packs Policy II.E.28 was revised and approved to meet manufactures requirements of 160F to 165F. Loss of Water policy II.B.69 was retired and policy II.B.31 will remain in place. Policy I.B.24 was revised to reflect the 180 (6 month) time frame.</p> <p>2. Policies will be revised on an annual basis.</p> <p>3. CEO is responsible</p> <p>4. Completed 2.20.2013 and governing board approved.</p>	02/20/2013

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	<p>for the hot packs was 160 F to 165 F. The department's logs reflect the manufacturer's requirements and confirmed the policy needs to be changed to reflect the requirements of the manufacturer's recommendations.</p> <p>3. Loss of Water policy #III-B.69 (last approved date 2/12) states, "The Material Management Department will maintain 3 gallons of water reserved per patient per day."</p> <p>4. Disruption Emergencies policy #III-B.31 (last approved date 2/12) states, "Disaster Coordinator and Disaster Team work out water rationing, estimating 3 gallons of water per day per patient."</p> <p>5. At 11:30 AM on 2/6/2013, staff member #2 indicated the facility has never stored 3 gallons of water per patient as defined in the policies. The staff member indicated the facility has a written agreement with AIM Water</p>						

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	<p>Treatment company for water emergency supply since 1/31/08. The staff member confirmed the facility does not have a written procedure defining the system the facility would follow and the current policy needs to be rewritten.</p> <p>6. Staff Competencies policy #I-B.24 (last approved 2/12) states, "ACLS certification for registered nurses if required for their position as identified in their applicable job description. Completed unit-specific competencies by the conclusion of the 90 day probationary period."</p> <p>7. Adult Cardiopulmonary Resuscitation policy #II-C.3 (last approved 2/12) states, "All RN's will be ACLS certified within 6 months of HIRE."</p> <p>8. At 1:45 PM on 2/6/2013, staff member #2 indicated the staff competencies policy was not amended to reflect the 180 day</p>			

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	<p>requirement for all RNs to have ACLS certification after they have been hired.</p> <p>9. At 2:15 PM on 2/6/2013, staff member #1 indicated the facility has several policies that need to be amended to reflect current practices.</p>			

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S000332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</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:</p> <p>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on policy and procedure review, job description review, personnel file review, and interview, the facility failed to ensure all registered nurses (RNs) had documentation in competency in blood transfusion administration for one of one agency RNs (#P2) and one of four facility RNs (#P14).</p> <p>Findings included:</p> <p>1. The facility policy "Use of Temporary Agency Staff and Independent Contractors", last reviewed February 2012, indicated, "b. Staffs provided from temporary agencies are not considered employees of the Hospital. Temporary help, however, is expected to adhere to all hospital and departmental policies and procedures. The department to which the</p>	S000332	<p>· Agency orientation o Attached copy of RiverCrest form: "<u>Departmental Orientation for Agency/Contract Employees</u>". o o Education of Staff: § The first-time facility agency nurse arrives 2-hours before the start of their scheduled shift. The attached orientation form is completed and signed prior to that shift. § Will re-educate nursing staff at the March staff meeting to continue to complete the '<u>Departmental orientation for Agency/Contract Employees' on all first-time agency staff</u>. Nurse manager is responsible. Human Resources will monitor any contract staff for compliance with appropriate compliance with orientation. · #: Blood transfusion training o RC nursing staff completed 2012 blood transfusion annual competency via Swank-online. Review and</p>	03/05/2013			

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	<p>temporary employee is assigned is responsible for providing adequate orientation to the job and department, including, but not limited to, age specific-criteria of a unit's patients, and for caregivers, the environment of care."</p> <p>2. Review of the Registered Nurse job description indicated, "6. Renders professional nursing care including administering medications, and initiating and maintaining intravenous fluids and blood products according to hospital policy and procedures."</p> <p>3. Review of the employee file for agency staff nurse #P2 indicated orientation completed 07/26/12, but lacked documentation of training or competency in blood transfusions or administration.</p> <p>4. Review of the employee file for staff nurse #P14 lacked documentation of annual competency in blood transfusions or administration.</p> <p>5. At 11:30 AM on 02/06/13, staff members #A1 and A2 indicated blood administration was one of the annual competencies, but could not provide documentation for nurses #P2 and P14.</p>		<p>revise PHS-Swank policy to provide manager with lists of assignment completion dates, and lists of staff that are noncompliant with scheduled competencies. o Attached copy of revised policy # C.7 `blood administration'. o Education of staff: § Mandatory education and testing via swank on blood administration P&P. Assignment date of March 5 2013 complete ion due by 03-25-2013. Nurse Manager is responsible and will monitor compliance via an online report.</p>				

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on policy and procedure review, observation, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage and by dating products according to manufacturer's directions.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Adult Cardiopulmonary Resuscitation", last reviewed 04/2012, indicated, "The new crash cart lock will be placed on the crash cart. Drugs are checked monthly by the pharmacy staff and if any outdated drugs are found, they are replaced with in-date stock." During the tour of the 100 unit with staff members #A1 and A2, beginning at 2:15 PM on 02/05/13, the following observations were made: <ol style="list-style-type: none"> An open, but not dated, container of Contour glucometer strips at the nurse station. Manufacturer's directions were to date the bottle when opened and discard after 180 days. 	S000554	<p>Outdated supplies crash cart o Revision of policy # <u>II-C.3A Adult cardiopulmonary resuscitation</u>. Page 2- supply check: Lists use of the form <u>Crash cart checklist- # RC-091RC/2009-09-22</u> to document that supplies are checked for 'outdates' every month and every time that the cart is opened/unlocked. . o Education: § Charge nurses will sign memo of understanding at the next staff meeting in March 2013 verifying review and understanding of this policy clarification. Nurse Manager is responsible and will provide audit on monthly basis for compliance.</p>	03/05/2013			

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	<p>B. One of four Arrow quick flash radial artery cath set with an expiration date of 06/2012 in the procedure cart.</p> <p>C. Three of three 5-0 Ethilon sutures with an expiration date of Jan. 2013 in the procedure cart.</p> <p>D. Five of five 3-0 Ethilon sutures with an expiration date of Jul. 2012 in the procedure cart.</p> <p>E. Three of five BD Insyte Autoguard intravenous catheters, 20 gauge, with an expiration date of 12/2010 in the crash cart.</p> <p>F. Four of five BD Insyte Autoguard intravenous catheters, 22 gauge, with an expiration date of 10/2012 in the crash cart.</p> <p>G. Three of three BD Insyte Autoguard intravenous catheters, 18 gauge, with an expiration date of 08/2010 in the crash cart.</p> <p>H. Two of two BD Insyte Autoguard intravenous catheters, 24 gauge, with an expiration date of 12/2010 in the crash cart.</p> <p>3. At 2:50 PM on 02/05/13, staff member #A2 indicated the charge nurse should check the supplies monthly, but the crash cart log of checks did not reflect this practice.</p> <p>4. During the tour of the 200 unit with staff member #A2, beginning at 3:20 PM</p>				

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	<p>on 02/05/13, the following expired items were observed in the crash cart:</p> <p>A. Two of seven BD Insyte Autoguard intravenous catheters, 20 gauge, expired 09/2010.</p> <p>B. One of one BD Insyte Autoguard intravenous catheters, 16 gauge, expired 01/2009.</p> <p>C. One of one BD Insyte Autoguard intravenous catheters, 18 gauge, expired 08/2010.</p> <p>D. Four of six Intravenous start kits, two expired 08/2011 and two expired 12/2012.</p> <p>5. During the tour of the bronchoscopy room at 3:40 PM on 02/05/13, accompanied by staff members #A2 and A8, an open, but not dated, container of Rapicide test strips was observed. Manufacturer's directions were to date the container when opened and discard after 90 days.</p> <p>6. At 1:30 PM on 02/06/13, staff member #A2 indicated nurses were to check the supplies whenever the crash cart was opened, but indicated there was no facility policy addressing this practice.</p>			

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S000672	<p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(e)</p> <p>(e) All nursing and other hospital personnel performing out-of-laboratory testing shall have annually updated performance certification maintained in the employee file for the procedures being performed.</p> <p>Based on policy and procedure review, laboratory document review, personnel file review, and interview, the facility failed to ensure all staff who performed out of lab testing had annual glucometer competency in 11 of 11 files reviewed (#P6, P7, P8, P9, P11, P12, P13, P14, P15, P16, and P17).</p> <p>Findings included:</p> <p>1. The facility policy "Staff Competencies", last reviewed February 2012, indicated, "2. Competency Tool: Competency of employees is re-evaluated annually by the appropriate department supervisor/director with job specific and hospital wide competency tools."</p> <p>2. The laboratory document provided by the facility indicated, "V. Annual Activities: A. The Laboratory Director/Pathologist will visit the site at least annually and review methods and procedures. B. The Laboratory Coordinator will oversee staff</p>	S000672	<p>Contour Glucose Monitor o The annual Contour glucose competency will consist of written quiz and skills validation test. The swank online education has began and is scheduled to be completed by all nursing staff by 03-01-2013. o Education: See attached forms: <u>'Contour Glucose Meter Quiz and Contour Meter Skills validation.'</u> Nurse Manager is responsible and will monitor compliance via online report.</p>	03/01/2013			

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	<p>competency for moderately complex testing and competency checks will be done by hospital POC (point of care) key contacts for all waived testing. ...II. Nursing staff performs Blood Glucose by Bayer Contour Meter..."</p> <p>3. Review of personnel files at 11:00 AM on 02/06/13 with staff member #A13 failed to evidence documentation of annual glucometer competency for 11 of 11 staff members who performed out of lab testing and who had been employed for over a year (#P6, P7, P8, P9, P11, P12, P13, P14, P15, P16, and P17).</p> <p>4. At 11:35 AM on 02/06/13, staff members #A1 and A12 indicated glucometer competency was conducted on new hires, but was not done annually.</p>				

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S000748	<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 policy and procedure review, medical record review, and interview, the facility failed to ensure all entries in the medical records were authenticated and dated according to policy for 9 of 15 history and physicals (#N1, N2, N4, N5, N7, N8, N10, N12, and N14) and for 9 of 15 discharge summaries (#N2, N5, N6, N7, N8, N9, N10, N12, and N14).</p> <p>Findings included:</p> <p>1. The facility policy "Timeliness of Medical Record Completion", last reviewed February 2012, indicated, "1. All medical record entries must be legible, complete, dated, timed, and authenticated promptly, in written or electronic form, by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. a. Dictated reports require not only a signature, but also the date and time the report was signed."</p> <p>2. The medical record for patient #N1,</p>	S000748	<p>1. Physicians and nurse practitioners have been educated on use of date and time on all entries. Ward clerk will assist providers by 'tagging' reports requiring signature, date, and time on a daily basis.</p> <p>2. Medical records will audit records for date and time on authentication and report montly.</p> <p>3. Chief Clinical Officer</p> <p>4. April, 1, 2013</p>	04/01/2013

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	<p>who was admitted 10/10/12, indicated a history and physical dictated 10/11/12 with a physician signature, but without a date or time for the signature.</p> <p>3. The medical record for patient #N2, who was admitted 04/12/12 and discharged 05/10/12, indicated a history and physical dictated 04/13/12 with a physician signature, but without a date or time for the signature. The record also indicated a discharge summary dictated 05/23/12 with a physician signature, but without a date or time for the signature.</p> <p>4. The medical record for patient #N4, who was admitted 12/13/12, indicated a history and physical dictated 12/14/12 with a physician signature, but without a date or time for the signature.</p> <p>5. The medical record for patient #N5, who was admitted 05/15/12 and discharged 06/07/12, indicated a history and physical dictated 05/16/12 with a physician signature, but without a date or time for the signature. The record also indicated a discharge summary dictated 08/02/12 with a physician signature, but without a date or time for the signature.</p> <p>6. The medical record for patient #N6, who was admitted 04/05/12 and discharged 05/25/12, indicated a</p>			

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	<p>discharge summary dictated 06/07/12 with a physician signature, but without a date or time for the signature.</p> <p>7. The medical record for patient #N7, who was admitted 06/01/12 and discharged 07/13/12, indicated a history and physical dictated 06/02/12 with a physician signature, but without a date or time for the signature. The record also indicated a discharge summary dictated 08/10/12 with a physician signature, but without a date or time for the signature.</p> <p>8. The medical record for patient #N8, who was admitted 10/15/12 and discharged 11/20/12, indicated a history and physical dictated 10/16/12, but without a physician signature, date or time. The record also indicated a discharge summary dictated 01/07/13, but without a physician signature, date or time.</p> <p>9 The medical record for patient #N9, who was admitted 11/27/12 and expired 11/30/12, indicated a discharge summary dictated 12/25/12, but without a physician signature, date or time.</p> <p>10. The medical record for patient #N10, who was admitted 07/11/12 and expired 08/05/12, indicated a history and physical dictated 07/12/12 with a physician</p>				

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	<p>signature, but without a date or time for the signature. The record also indicated a discharge summary dictated 08/10/12 with a physician signature, but without a date or time for the signature.</p> <p>11. The medical record for patient #N12, who was admitted 11/23/12 and discharged 12/07/12, indicated a history and physical dictated 11/24/12 with a physician signature, but without a date or time for the signature. The record also indicated a discharge summary dictated 01/07/13 with a physician signature, but without a date or time for the signature.</p> <p>12. The medical record for patient #N14, who was admitted 04/25/12 and discharged 05/21/12, indicated a history and physical dictated 04/26/12 with a physician signature, but without a date or time for the signature. The record also indicated a discharge summary dictated 06/07/12 with a physician signature, but without a date or time for the signature.</p> <p>13. At 2:45 PM on 02/06/13, staff member #A2 confirmed the medical record findings and staff members #A1 and A2 indicated the dating and timing of signatures had been an ongoing problem.</p>				

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S000870	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure verbal/telephone orders were authenticated by the physician according to policy for 15 of 15 closed medical records reviewed (#N1 through N15).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Verbal Written Orders- General Practices", last reviewed 01/2012, indicated, "The person receiving the order will first put the order in writing and then he/she will 'read back and verify' the order. ...The prescribing practitioner must sign the written record of the verbal/telephone order within 48 hours." The medical record for patient #N1 	S000870	<ol style="list-style-type: none"> Physicians and nurse practitioners have been educated on use of date and time on all entries. Ward clerk will assist providers by 'tagging' reports requiring signature, date, and time on a daily basis. Medical records will audit records for date and time on authentication and report montly. Chief Clinical Officer April, 1, 2013 	04/01/2013	

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	<p>indicated several verbal/telephone orders, including ones from 10/16/12, 10/18/12, and 10/23/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy. Two of the orders contained a stamp which provided spaces for the physician's signature, date, and time, but which were not utilized.</p> <p>3. The medical record for patient #N2 indicated a telephone order from 04/25/12 which was signed by the physician, but not dated or timed, making it unable to determine adherence to policy.</p> <p>4. The medical record for patient #N3 indicated several verbal/telephone orders, including ones from 11/30/12, 12/01/12, 12/02/12, and 12/03/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy.</p> <p>5. The medical record for patient #N4 indicated several verbal/telephone orders, including ones from 01/11/13 and 01/16/13 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy.</p> <p>6. The medical record for patient #N5 indicated several verbal/telephone orders,</p>				

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	<p>including ones from 05/15/12, 05/25/12, and 05/30/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy.</p> <p>7. The medical record for patient #N6 indicated several verbal/telephone orders, including ones from 04/06/12, 04/07/12, 04/25/12, and 05/04/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy. One of the orders contained a stamp which provided spaces for the physician's signature, date, and time, but which was not utilized.</p> <p>8. The medical record for patient #N7 indicated several verbal/telephone orders, including ones from 06/01/12, 06/08/12, 06/14/12, 06/18/12, 06/30/12, and 07/10/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy. Two of the orders contained a stamp which provided spaces for the physician's signature, date, and time, but which were not utilized.</p> <p>9. The medical record for patient #N8 indicated several verbal/telephone orders, including ones from 10/18/12, 10/27/12, and 10/29/12 that were signed by the physician, but not dated or timed, making</p>				

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	<p>it unable to determine adherence to policy. The record also indicated printed restraint orders from 11/05/12, 11/07/12, and 11/08/12 that lacked a physician signature, date or time.</p> <p>10. The medical record for patient #N9 indicated several verbal/telephone orders, including ones from 11/29/12 and 11/30/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy. One of the orders contained a stamp which provided spaces for the physician's signature, date, and time, but which was not utilized.</p> <p>11. The medical record for patient #N10 indicated several verbal/telephone orders, including ones from 07/11/12 and 07/17/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy.</p> <p>12. The medical record for patient #N11 indicated several verbal/telephone orders, including ones from 12/10/12, 12/12/12, and 12/13/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy.</p> <p>13. The medical record for patient #N12</p>						

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	<p>indicated several verbal/telephone orders, including ones from 11/23/12 and 11/26/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy. One of the orders contained a stamp which provided spaces for the physician's signature, date, and time, but which was not utilized.</p> <p>14. The medical record for patient #N13 indicated several verbal/telephone orders, including ones from 11/18/12 and 11/20/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy.</p> <p>15. The medical record for patient #N14 indicated several verbal/telephone orders, including ones from 04/25/12 and 04/26/12 that were signed by the physician, but not dated or timed, making it unable to determine adherence to policy. Two of the orders contained a stamp which provided spaces for the physician's signature, date, and time, but which were not utilized.</p> <p>16. The medical record for patient #N15 indicated several verbal/telephone orders, including ones from 10/31/12, 11/05/12, and 11/11/12 that were signed by the physician, but not dated or timed, making</p>			

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	<p>it unable to determine adherence to policy. One of the orders contained a stamp which provided spaces for the physician's signature, date, and time, but which was not utilized.</p> <p>17. At 2:45 PM on 02/06/13, staff member #A2 confirmed the medical record findings and staff members #A1 and A2 indicated the dating and timing of signatures had been an ongoing problem.</p>			

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S000952	<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 review, medical record review, and interview, the facility failed to ensure blood transfusions were administered according to facility policy for 5 of 5 patients who received blood transfusions (#N3, N4, N5, N6, and N7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Blood Administration", last reviewed February 2012, indicated, "6. Do pre-vital signs and document on blood transfusion Flow Sheet. ...16. Stay with patient and monitor for signs of reaction for first 15 to 30 minutes. 17. Monitor vital signs every 15 minutes for the first hour and then every half hour until unit is infused." The medical record for patient #N3 indicated a unit of packed red blood cells (PRBCs) was started at 1250 on 12/02/12 with the 15 minute vital signs 	S000952	<p>Blood Administration o The policy for Blood Administration # II-C.7 is revised to reflect current practices of Utilization of SBMF blood bank form to document vital signs during a transfusion. Specifically vital signs pre-transfusion; 15 minutes into transfusion, and post transfusion. o See attached policy revision: "<u>Blood Administration II-C.7</u>" o Education: Mandatory education and testing via Swank-online . Completed by March 1, 2013. Nurse Mangager is responsible and will monitor compliance online via online education tool.</p>	03/01/2013			

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	<p>documented at 1300 and the post-transfusion vital signs documented at 1650. The transfusion record only had areas for pre-transfusion vital signs, first 15 minutes vital signs, and post-transfusion vital signs. The daily charting flow sheet indicated documentation of vital signs taken at 1400, 1500, and 1600, but not every 15 minutes and every half hour as specified in the policy.</p> <p>3. The medical record for patient #N4 indicated a unit of PRBCs was started at 1745 on 01/11/13 with the pre-transfusion vital signs written over/unclear, 15 minutes vital signs documented at 1800, and the post-transfusion vital signs documented at 2100. The transfusion record only had areas for pre-transfusion vital signs, first 15 minutes vital signs, and post-transfusion vital signs. The daily charting flow sheet indicated documentation of vital signs taken at 1900 and 1930, but not every 15 minutes for the first hour as specified in the policy.</p> <p>4. The medical record for patient #N5 indicated a unit of PRBCs was started at 1850 on 05/30/12 with the 15 minute vital signs documented at 1905 and the post-transfusion vital signs documented/written over at 2030. The</p>						

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	<p>transfusion record only had areas for pre-transfusion vital signs, first 15 minutes vital signs, and post-transfusion vital signs. The daily charting flow sheet also indicated documentation of vital signs taken at 1830, 1905, and 2030, but not every 15 minutes and every half hour as specified in the policy.</p> <p>5. The medical record for patient #N6 indicated a unit of PRBCs was started at 1650 on 05/10/12 with the 15 minute vital signs documented at 1705 and the post-transfusion vital signs documented at 1850. A second unit of PRBCs was started at 1935 with the 15 minute vital signs documented at 1945 and the post-transfusion vital signs documented at 2230. The transfusion record only had areas for pre-transfusion vital signs, first 15 minutes vital signs, and post-transfusion vital signs. The record lacked documentation of the remaining 15 minute and half hour vital signs for either unit.</p> <p>6. The medical record for patient #N7 indicated a unit of PRBCs was started at 0000 on 06/09/12 with the 15 minute vital signs documented at 0002 and the post-transfusion vital signs documented at 0345. The transfusion record only had areas for pre-transfusion vital signs, first 15 minutes vital signs, and</p>						

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	<p>post-transfusion vital signs. The daily charting flow sheet also indicated documentation of vital signs taken at 0145 and 0245, but not every 15 minutes and every half hour as specified in the policy.</p> <p>The patient received two additional units of PRBCs on 06/30/12 and the documentation for the first unit indicated 1430 for the pre-transfusion vital signs, the start time, and the 15 minute vital signs. The post-transfusion time was written over/changed to 1600. The second unit was started at 1610 with 15 minute vital signs documented at 1625 and post-transfusion vital signs documented at 1810. The record lacked documentation of the remaining 15 minute and half hour vital signs for either unit.</p> <p>7. At 1:30 PM on 02/06/13, staff member #A2 confirmed there were some issues with vital sign documentation according to policy.</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 documentation review and observation, the facility failed to ensure the hospital environment was maintained in a safe manner for the Housekeeping Closet, Main Electrical Room, and Boiler Room.</p> <p>Findings included:</p> <p>1. Right to Know policy III-B.53 (last approved 2/12) indicates the facility was to ensure the manufacturer's safety recommendations are followed as how the employees are to handle every product that is used in the hospital. The policy also mandates the hospital to comply with OSHA standards for workplace safety.</p>	S001118	<p>Condition of Physical Plant and improper use of chemicals without adequate eyewash station</p> <ul style="list-style-type: none"> o Removal of all improper materials and equipment from the Main Electrical Room and Boiler room. Attached Pictures of current main electrical room and Boiler Room. o Improper materials and equipment were put in a proper storage closet o Instructed facilities personnel to maintain condition of the Main Electrical Room and the Boiler Room to insure that they are not a hazard to patients, public or employees. o Removal of open chemicals from Housekeeping Closet. · All will be added to safety rounds inspections. o Installation of auto dispensing unit to dispense chemicals.s o Installation of eye wash station in housekeeping closet. o Installation of a auto-dispensing unit for chemical. Responsible party, Klye Small CEO. Start Date 	02/07/2013	

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	<p>2. Because 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 eyes shall be provided within the work area for immediate emergency use.</p> <p>3. At 3:25 PM on 2/15/2013, the main housekeeping room was inspected. The room had a wire shelving unit that held assorted chemicals. One of the chemicals was a gallon container of Extraction Cleaner. The chemical is poured manually and not from an automatic dispensing unit. The manufacturer's label requires a 15-minute flushing of the eyes if the chemical would come in contact with the eyes. The housekeeping room did not have an eye-washing station to meet the 15-minutes of continuous flushing.</p> <p>4. Interim Life Safety policy #III-B.41 (last reviewed 2/12)</p>		2,6,2013 End Date: 2/7/2013				

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	<p>states, "All exits and exit corridors will remain clear and unobstructed at all times. Enforce storage, housekeeping, and debris removal practices that reduce the flammable and combustible fire load of the building to the lowest level necessary for daily operations."</p> <p>5. At 3:35 PM on 2/5/2013, the main High Voltage Electrical room was inspected. The electrical panels were on 2 walls directly across from each other, approximately 40 inches face-to-face. The room was observed cluttered with assorted items stored on the electrical panels: milk crates, paper diagrams, aerosol cans, etc. On the floor in the room were cardboard boxes of assorted maintenance supplies, plastic tubs, electrical heater, etc. At one end of the room was a plastic storage shelf with assorted flammable items: aerosol can, paints, paper, and other maintenance supplies. The window ledge was also observed storing</p>			

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	<p>assorted maintenance supplies in cardboard boxes.</p> <p>6. At 3:45 PM on 2/5/2013, the Boiler Room was inspected. The double Fire Door was observed obstructed with a 2-wheel hand cart and other industrial maintenance equipment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152026		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2013	
NAME OF PROVIDER OR SUPPLIER RIVERCREST SPECIALTY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1625 E JEFFERSON BLVD MISHAWAKA, IN 46545			
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S001186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the hospital was conducting a fire drill per shift per quarter as defined in the facility's policies and procedures and failed to assess the effectiveness of each fire drill that was conducted.</p> <p>Findings included:</p>	S001186	<p>Facility was not following policy on Fire Drills. o Safety director has changed the fire drill evaluation to document fire drills are conducted per policy on each shift. Facility administrator will sign off on the evaluation form to insure that policy is being followed. Updated form is attached. o Safety director will document the findings of the fire drill on the Fire Drill Evaluation form. CEO will review evaluation comments form and sign off for approval of proper documentation.</p>	02/07/2013			

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	<p>1. Fire Plan policy #III-B.39 states, "Fire Drills shall be conducted at least quarterly on all shifts are treated and housed. A fire drill checklist is used to assess the effectiveness of the staff members, results are reviewed and a short question and answer session is held.</p> <p>2. At 2:30 PM on 2/5/2013, staff member #5 indicated the facility operates under a two shift system: 7 to 7.</p> <p>3. Fire Drills were reviewed for 2012. The facility conducted 1 drill the first quarter, 3 drills the second quarter, 3 drills the third quarter, and 2 drills the fourth. All 9 drills were conducted on the 1st shift between 8:30 AM and 6:01 PM. The hospital documentation did not evidence a fire drill was conducted on the second shift of all four quarters.</p> <p>4. The Fire Drill Observer Evaluation forms were reviewed for</p>		<p>· Responsible party, Klye Small CEO. Start Date 2,6,2013 End Date: 2/7/2013</p>				

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	<p>2012. The evaluation forms did not evidence comments or evaluations on how the fire drills were conducted.</p> <p>5. At 2:35 PM on 2/5/2013, staff member #5 indicated he/she was unaware that a fire drill was to be conducted 1 per shift per quarter. The staff member indicated the fire drills are not evaluated as per policy. The staff member indicated the Nurse Managers would direct the staff on the fire drills. Staff member #5 indicated he/she just activates the drill.</p>				