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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150023 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 02/25/2015 |
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| S 000 Bldg. 00 | <p>This visit was for a State hospital licensure survey.</p> <p>Dates: 2/23/2015 through 2/25/2015</p> <p>Facility Number: 005022</p> <p>Surveyors: Albert Daeger, BS CFM Medical Surveyor</p> <p>Jack Cohen, MHA Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>Marcia Anness, RN PH Nurse Surveyor</p> <p>QA: claughlin 03/17/15</p> | S 000 | | |
| S 270 | 410 IAC 15-1.4-1 GOVERNING BOARD | | | |

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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| Bldg. 00 | <p>410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality activities for 4 services for the calendar year 2014.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2014 indicated they did not include review of reports for biohazardous waste hauler, EEG (Electroencephalography), EMG (electromyelography), and social services.</p> <p>2. In interview, on 2-25-15 at 11:15 am, this was confirmed by employee #60, Assistant Director Quality, and no other documentation was provided prior to exit.</p> | S 270 | <p>How are you going to correct deficiency?1. Four areas noted missing have been added to a master listing of reporting QAPI department, unit, and contract services for the facility. Reviewed entire listing to ensure other key location/services were not missing from reporting, no other areas noted. (Attachment A) 2. April 7, 2015 a facility summary of QAPI for 2015 will be submitted to Quality Steering Committee (QSC). These four areas will be included on this report. The report will then be forwarded onto our Board Quality meeting on April 9, 2015. (Attachment B)3. At April 7 QSC meeting will review master listing of report QAPI department, unit, contract services for any deletions or revisions. How are you going to prevent deficiency from recurring in the future?1. Added to QSC review agenda the task of</p> | 04/16/2015 |

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| S 406 Bldg. 00 | <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. Based on document review and interview, the hospital failed to have an effective comprehensive quality assessment and improvement program in 1 instance, failed to include monitors and standards for 1 service provided by a contractor, and failed to include standards for 10 other services, as part of its comprehensive quality assessment and</p> | S 406 | <p>reviewing the master reporting list at least annually to help manage revisions, deletions, or additions to needed reporting areas. 2. Reporting of QAPI details will be reported to QSC a minimum of twice a year (April/Oct) with information flowing up to our Board Quality. Who is responsible? Rhonda Smith, VP Patient Care Services, CNO Completion Date: April 16, 2015</p> <p>How are you going to correct deficiency? 1. Indicator, reporting frequency and standard for Biohazard Waste Hauler completed. Information and approved at March 26, 2015 EOC mtg. Information will flow up to QSC April 7, 2015 and then to Board Quality- April 16, 2015. (Attachment A- S406) 2. Medical Staff contracts with unidentified</p> | 04/08/2015 |

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| | <p>performance improvement (QAPI) program for calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility's 2014 QAPI program indicated performance measures for a project entitled HFAP Glycemic Control Chart, Data Measured During the CHECK Phase. 2. The data for an indicator, entitled Percent of patients that triggered for two consecutive glucose values >180, with discharge dx of DM and A1c result during hospitalization, indicated a goal of $\geq 90\%$. 3. Review of the monthly outcomes in calendar year 2014 indicated outcomes in a range from 33% to 71%, an overall average of 45%, and no appreciable trending toward the goal. 4. In interview, on 2-24-15 at 10:45 am, employee #60, Assistant Manager Quality, indicated various actions were taken to address the above-stated issue, but the results have been significantly below goal for 15 straight months. 5. Since the data and employee #60 indicated the results have averaged 45% vs. a goal of | | <p>standards (ambulance, blood bank, lithotripsy, security, teleneurology and teleradiology) will be discussed at MEC at next scheduled April 7, 2015 meeting. MEC will determine standards for monitored elements and update on future reporting. (Attachment B- S406) 3. Reporting areas for Pharmacy, EEG, and EMG have been confirmed with Directors/Managers set standards for reporting QAPI indicators and will report those elements on future reports to respective committees. These will be reported at the QSC on April 7, 2015. 4. March 27, 2015- Director of Quality and Infection Control provided education flyer and email to members of QSC and leaders/team leaders. Flyer and email highlighted need for established standards for reported indicators as well as need to consistently evaluate goals and address goals performance that have not shown improvement. (Attachment C &D) 5. Issue for discussion surrounding standards reporting as well as goal and performance evaluation will be presented at the QSC scheduled for April 7, 2015. (Attachment E) 6. Director of Quality/Infection Control will provide education at next Leadership meeting set for April 8, 2015 related to QAPI establishment of standards as well as consistent review of goals performance to be discussed at</p> | |

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| | <p>≥ 90%, no appreciable trending toward the goal, and yet certain actions were taken for improvement, it can be concluded the actions taken were ineffective.</p> <p>6. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted service of biohazardous waste hauler.</p> <p>7. In interview on 2-25-15 at 11:15 am, this was confirmed by employee #60, Assistant Manager Quality, and no other documentation was provided prior to exit.</p> <p>8. Review of the facility's QAPI program for calendar year 2014 indicated it did not include standards for the services of ambulance, blood bank, EEG (Electroencephalography) and EMG (electromyography), extracorporeal shock wave lithotripsy, pharmacy, security, social services, teleneurology and teleradiology.</p> <p>9. In interview on 2-25-15 at 11:15 am, this was confirmed by employee #60 and no other documentation was provided prior to exit.</p> | | <p>the April 8, 2015. How are you going to prevent? 1. Prevention will require ongoing diligent review of all reported QAPI indicators presented at respective committees to ensure standards are clearly identified. Areas not meeting requirement will be required to establish standard prior to next reporting cycle. 2. Any reporting of consistent negative data trends from standard must include reporting of action items taken to improve performance. Actions could include but not limited to: specific drill down, formal action plan, up to revision of established standard. Who is responsible? Rhonda Smith, VP Patient Care Services, CNO Completion Date: April 8, 2015</p> | | |

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| S 554 Bldg. 00 | <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 documentation review and staff interview, the hospital failed to ensure the temperatures were maintained between 68 and 73 degrees Fahrenheit for 12 of 12 operating rooms, failed to store nutritional supplement according to the manufacturer's recommendation in 8 instances and failed to ensure that Accucheck Control Solution was dated when opened on 2 of 8 units and was not dated greater than the 90 days manufacturer's recommendation discard date on 1 of 1 unit.</p> <p>Findings included:</p> <p>1. Union Hospital Terre Haute Daily Temperature and Humidity Reading Logs of Surgery, SPD,</p> | S 554 | <p>How are you going to correct the deficiency? <u>OR Temperatures</u> 3/31/15 Policy Revision- Plant will maintain temperature/humidity based on current facility policy. Request for variation in temperatures will need to be initiated by physician/anesthesia provider. Request for temperature change will be filed via the Help Desk to allow for tracking of requests. (Attachment A-S554) 3/26/15 Surgery Educator began best practices and literature search related to this issue. Will present new information and options such as cooling vests, coolers for cement, & risk tools for variations to applicable committees as details present. 3/31/15 Plant staff educated on keeping OR suite temperatures/humidity within policy guidelines and only variations will occur at request of physician/anesthesia provider. 4/2/15 Storytelling as well as education poster/policy (#2184) on OR temperature requirements and variation request process</p> | 04/30/2015 |

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| | <p>ASC, Labor and Delivery policy #2184 (last reviewed 8/2014) indicated temperature readings for each Operating Room, SPD, ASC, and Labor and Delivery rooms will be maintained at 68 to 73 degrees Fahrenheit.</p> <p>2. O.R. Temps & Humidity logs were reviewed for the period between 2/13/2015 through 2/20/2015. The log sheets included data for: OR-1, OR-2, OR-3, OR-4, OR-5, OR-6, OR-7, OR-8, OR-9, OR-10, OR-11, and OR-12. The eight day period reviewed had recorded the temperatures on 6-hour intervals for each Operating Room, which resulted in 32 recorded times per Operating Room. The temperature logs reviewed evidenced the temperatures of the Operating Rooms never exceeded 66 degrees Fahrenheit and were as low as 59 degrees Fahrenheit. Therefore, the 12 Operating Rooms did not comply with the temperature requirements defined in Union</p> | | <p>provided to OR staff. (Attachment B-S554) 4/6/15 The VPMA to present at MEC- education on OR temperature requirements and variation request process. (Attachment C-S554) 4/13/15 The Director of Surgery will present education of OR temperature requirements and variation request process at the Department of Surgery and again at the OR Committee 4/16. (Attachment D & E-S554) <u>Nutrition Supplement:</u> 2/26/15 Formula bottles out of boxes were removed and discarded. (Attachment F-S554) 2/26/15 Verbal education was provided to staff, shift to shift on proper storage of formula and not to bring open boxes of formula back from nursing units. Open items to be discarded. 3/25/15 A written reminder notice sent to all staff regarding proper storage of formula. (Attachment G-S554) 4/14/15 Proper storage of formula will be discussed at staff meeting. <u>AccuChek Control Solution:</u> 2/28/15 Point of Care Coordinator (POCC) removed all Accucheck control solutions housewide and replaced with new solutions appropriately labeled as per policy. Utilized stickers for process, reducing opportunity for smudging and rubbing off of dates. 3/15 Revised policy Blood Glucose Monitoring Quality Management Plan – added new process where Quality Control solutions will be dispersed and</p> | | |

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| | <p>Hospital Terre Haute policy #2184.</p> <p>3. At 2:00 PM on 2/24/2015, staff member #5 (Maintenance Manager) indicated that staff requested the temperature below 68 degrees Fahrenheit.</p> <p>4. On 2-23-15 at 1:45 pm, in the presence of employees #3, Facilities Director, #4, System Director Safety/Risk Management, and #5, Maintenance Manager, it was observed in the General Storage area, there were the following stored on an open shelf, uncovered and unprotected, completely exposed to the light:</p> <p>4 2 oz. bottles Similac Sensitive Care nutritional supplement 4 2 oz. bottles Similac Expert Care nutritional supplement</p> <p>5. Review of the manufacturer's label on each bottle indicated Avoid Prolonged Exposure to Light.</p> <p>6. Due to the prolonged exposure</p> | | <p>marked appropriately every 90 days by the POCC. (Attachment H-S554) 3/15 Healthstream staff education regarding Accuchek Quality Control is part of yearly mandatory education for staff- This was completed in March and covers elements of quality control solutions. Accuchek Validation completed at 96.46% (Attachment I-S554 pg 8) 4/21/15 Update of process and policy will be presented at next Shared Governance meetings, information to be shared at unit level councils. How are you going to prevent the deficiency from recurring in the future? <u>OR Temps:</u> Plant will begin reporting monthly number of variances in temperature/humidity by OR Suite Quality Steering Committee (QSC) for next 3 months. Reporting to QSC will begin April 7, 2015. These details as well as request received for variances via Help Desk will be forwarded to OR Committee (4/16) and OR Committee (4/23) for further review. Tracking will be evaluated by QSC at the end of 3 months to determine if further tracking or additional actions are required. <u>Nutrition Supplement:</u></p> <p>1. Monitoring for appropriate storage will be part of the daily process performed by designated inventory control staff member.</p> <p>2. Results from daily inventory control will be reported to Quality Steering Committee (QSC) for next three months. Reporting to</p> | | | | |

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| | <p>to light, the above items may have become ineffective.</p> <p>7. During the tour on 02/23/15 beginning at 12:45 PM on the Medical/Surgical Unit 3EA, accompanied by staff members #22 and #35, 4 of 4 open bottles of Accucheck Control Solution were observed to not have a discard date.</p> <p>8. During tour on 02/23/15 beginning at 11:00 AM on the General Surgery Unit, accompanied by staff members #22 and #35, 2 of 2 open bottles of Accucheck Control Solution were observed to not have a discard date.</p> <p>9. During the tour on 02/24/15 beginning at 9 AM on the Acute Rehab Unit, accompanied by staff #22 and staff #35, 2 of 2 open bottles of Accucheck Control Solution were observed with a written discard date of 05/31/15, which was greater than the 90 day after opening discard date on the</p> | | <p>QSC will being April 7, 2015. Goal is to be 100% compliant. Results will be re-evaluated at end of three months to determine if continued reporting is required. <u>AccuChek</u>: 1. POCC will be responsible for dispersing Quality Control and maintaining log of when solutions are changed, noting lot number, date opened, and expiration date. 2. Results of log will be submitted to QSC – starting April 7, 2015 and again in 90 days to validate control solutions have been changed out according to policy. (Attachment J-S554) Who is responsible: Rhonda Smith, VP Pt Care Services, CNO Date Completed: 4/30/15</p> | | |

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| S 608 Bldg. 00 | <p>manufacturer's label.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure the surgical staff followed their dress code policy and nationally recognized guidelines regarding surgical masks.</p> <p>Findings included:</p> <p>1. The facility's policy "Scrub Suit/Dresses in Restricted Areas", last reviewed 01/15, indicated, "5. All individuals entering restricted areas of the OR [Operating Room] suite should</p> | S 608 | How are you going to correct the deficiency? 3/13/15 Storytelling on issue with Labor Room staff. 3/25/15 Mandatory surgical mask education poster /policy in Labor room- required read and sign off. (Attachment A-S608) 3/26/15 Educational email sent to Surgery/Outpt Surgery staff related to appropriate use of surgical masks. (Attachment B-S608) 4/2/15 Discussed at staff meeting as well as mandatory surgical mask education poster/policy read in by OR Staff- required read and sign | 04/23/2015 | | | |

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| | <p>wear a mask when open sterile items and equipment are present. ...b. Masks should be removed carefully by handling only the ties, and they should be discarded immediately. Masks should not be saved by hanging them around the neck or tucking them into a pocket for future use. The filter portion of a surgical mask harbors bacteria from the nasopharyngeal airway. Handling this portion of the mask after use can transfer bacteria to the hands and initiate potential cross contamination." The policy referenced "Recommended Practices for Surgical Attire, Association of Operating Room Nurses, 2014, Standards and Recommended Practices."</p> <p>2. During the tour of the surgical and pre/post areas between 1:00 PM and 1:35 PM on 02/23/15, accompanied by staff members #23, the OR Systems Director, and #25, the OR Manager who was wearing a mask around his/her neck, seven different staff members were observed traveling back and forth between the pre/post and surgical areas with masks hanging around their necks, dangling on the fronts of their scrub tops, and one, hanging around the back of the neck.</p> <p>3. During the tour of the obstetrical area and C/S (Cesarean Section) rooms</p> | | <p>off. (Attachment C-S608) 4/2/15 Education poster on surgical mask attire appropriateness will be posted in Surgeon/Anesthesia & L& D lounge. (Attachment D-S608) 4/6/15 VPMA will present issue of surgical mask attire appropriateness to Medical Staff at MEC on April 6, 2015. (Attachment E-5608) 4/13 & 4/23/ 15- Director of Surgery will present to issue to Department of Surgery on April 13, and OR Committee on April 23. (Attachment F & G-S608) 4/16/15- Director of OB/Gyn will present surgical mask attire appropriateness at the Perinatal meeting How are you going to prevent the deficiency from recurring in the future? 1. Managers and Directors from the respective reporting units will begin weekly "Secret Shopper" monitoring on mask attire appropriateness compliance. Weekly monitoring will begin April 6. Issues of concern will be addressed real time and "Secret Shopper" reporting results will be shared with staff. (Attachment H-S608) 2. Compliance for areas related to monitoring surgical mask attire appropriateness will be reported up to Quality Steering Committee x 3 months and then re-evaluated for need of continued monitoring. Details will also be shared at respective Medical Staff meetings. Who is responsible: Rhonda Smith, VP Pt Care Services, CNO Date</p> | |

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| S 754 | <p>between 2:00 PM and 2:30 PM on 02/23/15, accompanied by staff member #28, a registered nurse, three different staff members were observed walking around and sitting at the station with masks hanging around their necks.</p> <p>4. During the tour of the Out-Patient Surgery Center between 1:00 PM and 2:00 PM on 02/24/15, accompanied by staff members #46, a the center's manager, and #48, the center's OR supervisor, six different staff members were observed walking around, sitting at the control desk, then walking back to the OR suites with masks hanging around their necks.</p> <p>5. At 1:15 PM on 2/23/15, staff member #25 confirmed the facility followed AORN guidelines.</p> <p>6. At 1:30 PM on 2/24/15, staff members #46 and #48 confirmed the facility followed AORN guidelines which also indicated surgical masks should be removed at the completion of each case and not worn around the neck.</p> <p>410 IAC 15-1.5-4</p> | | Completed: 4/23/15 | | |

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| Bldg. 00 | <p>MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on medical record review and interview, the facility failed to ensure that Consent for Treatment was obtained for 2 of 2 newborns.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Medical record review indicated medical records #13 and 16 did not have evidence of a Consent for Treatment. 2. At 3:00 PM on 2/24/15, staff member #31 (RN) verified that the above medical records did not include a Consent for Treatment. | S 754 | <p>How are you going to correct the deficiency? 2/24/15 Labor Room staff educated on obtaining consents for treatment upon delivery. Instructed not to use mothers label on consent, must be babe's information. 3/26/15- Mandatory education poster for staff : All consents for newborns must be placed on the newborn chart with the newborn sticker in appropriate corner of consent. To be completed by April 10, 2015. (See Attachment A -S754)</p> <p>How are you going to prevent the deficiency from recurring in the future? 1. 3/30/15- Weekly audits of 10 newborn charts on Mother/Baby and 5 new admits to NICU to be completed. Monitoring will continue until 100% compliance is met for 4 weeks. (Attachment B-S754) 2. Monitoring results will be forwarded to Quality Steering Committee for oversight and tracking. Who is responsible:</p> | 04/30/2015 | |

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| S 932 Bldg. 00 | <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on medical record review and interview, the facility failed to ensure that care plan interventions were initiated.</p> <p>Findings:</p> <p>1. Review of medical records indicated: (a) Patient #2 care plan intervention to "Encourage family to learn CPR". The record did not indicate that this intervention was initiated. (b) Patient #9, 14, 15 and 18's care plan intervention to "Teach patient/family handwashing practices". The records did not indicate that these interventions were initiated.</p> <p>2. At 3:00 PM on 2/24/15, staff member #31(RN) verified that the above medical records did not include evidence that care plan interventions were initiated.</p> | | | S 932 | <p>Rhonda Smith, VP Pt Care Services, CNO Date Completed: 4/30/15</p> <p>How are you going to correct the deficiency? 3/15/15 Healthstream assigned to address new revisions in current Interdisciplinary Plan of Care (POC). Education focus on new features in the system. Current process is cumbersome as related to review and documentation of POC interventions. No central location for pending interventions, requires staff to log into other areas to document education. The new revised process for interventions for education will populate the nurses work list and when selected to complete will tak staff to the teaching/learning screen to document. The task stays visible on the nurses work list for this patient until task is completed and documented. The nurse work list is a driving feature in the day to day care of the patient. (Attachment A-S932) 3/22/15 Required "hands</p> | | 04/21/2015 |

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| S 952 Bldg. 00 | 410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy and procedure review, medical record review, and interview, the | S 952 | on" staff education for new module. This education also addresses the active work list and documentation enhancements. 4/21/15 Module Plan of Care revision go liveHow are you going to be able to prevent the deficiency from recurring in the future? Monitoring will begin 4/22/15. Tracking will include a weekly review of 10 inpatient discharges and review that all POC active interventions were completed. Information will be shared with nursing leaders with results forwarded up to the Quality Steering Committee. Tracking will continue for 2 months and be re-evaluted to determine if further action is needed of tracking my be discontinued. Who is responsible: Rhonda Smith, VP Pt Care Services, CNODate Completed: 4/21/15 How are you going to correct the deficiency? 3/31/15 Education | 04/21/2015 |

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| | <p>facility failed to ensure physician orders and policy were followed regarding blood transfusions for 2 of 5 patients receiving blood transfusions (#B1 and B5).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Blood Administration/Reactions", last revised 11/13, indicated, "Equipment: Physician's order for transfusion, signed consent ...Procedure: Check the physician's order for component and number of units to be infused and any other directions for blood administration. ...Note: Confirm that consent for transfusion has been obtained." The medical record for patient #B1 indicated a physician order for two units of PRBCs (packed red blood cells) on 02/20/15, which were administered, but the record lacked documentation of a signed consent for the transfusion. The medical record for patient #B5 indicated a physician order on 12/04/14 to transfuse two units of PRBCs and also an order to give Lasix 20 mg. (milligrams) IV (intravenous) push one dose post transfusion. The record indicated the first unit was started at 1735 hours on 12/04/14 and completed at 1930 hours with the second unit started at 2301 | | <p>provided to all staff on obtaining blood consent and following of physician orders. The Blood Administration Policy, #2599 (see Attachment A-S952) has been given to each nursing care unit for staff to read and sign. Also education piece on following Medical Staff orders have been given for staff to read and sign (Attachment B S952) Education to be completed by 4/10/15. 3/31/15 The blood policy and consent requirement as well as following Medical Staff orders will also be verbally discussed by NCM or ANCM at staff meetings, daily huddles. 4/21/15 Storytelling and education related to issues for blood consent and following physician orders will be presented at Shared Governance and up through April Unit Councils. How are you going to prevent the deficiency from recurring in the future? 1. April 6, 2015- Each unit will complete review of 5 blood charts. The charts will be screened for completed consent on report as well as adherence to physician orders. Process will be overseen and monitored monthly by Director. Goal is 100% compliance. 2. The monthly summary of performance will be forwarded up to Quality Steering Committee Reviews will continue for 3 months and be re-evaluated to determine if further action is needed or if tracking may be discontinued. Report to QSC</p> | |

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| S 118 Bldg. 00 | <p>hours on 12/04/14 and completed at 0056 hours on 12/05/14. The Medication Administration Record indicated the dose of Lasix was given at 2047 hours on 12/04/14, which was between the two units and not at the completion of the transfusion.</p> <p>4. At 10:30 AM on 02/25/15, staff member #31, the RN (Registered Nurse) Clinical Infomatics who navigated the EMR (Electronic Medical Record), confirmed the lack of a transfusion consent for patient #B1 and confirmed the physician order was not followed for patient #B5.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, facility document review, interview, policy and procedure</p> | | | S 118 | <p>5/5/15 Who is responsible: Rhonda Smith, VP Pt Care Services Date Completed: 4/21/15</p> <p>How are you going to correct the deficiency? <u>Alcohol-based hand dispenser:</u></p> | | 04/21/2015 |

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| | <p>review, and manufacturer's guidelines, the facility failed to ensure a safe environment for patients by following standards of practice regarding an alcohol-based hand sanitizer (ABHS) and warming cabinets.</p> <p>Findings:</p> <p>1. On 2-23-15 at 2:12 pm in the presence of employees #3, Facilities Director, #4, System Director Safety/Risk Management, and #5, Maintenance Manager, it was observed in the Dirty Laundry area, there was an alcohol-based hand sanitizer (ABHS) on the wall directly above an electrical light switch. This posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source.</p> <p>2. During the tour of the off-site Infusion Therapy Center at 1:30 PM on 02/23/15, accompanied by staff members #10, the infusion tech, #11, the infusion director, #12, the Oncology Systems Director, and #13, the Director of Imaging, a warming unit containing only blankets was observed registering 149 degrees F (Fahrenheit) and set at 150 degrees F. No temperature monitoring log was available or provided by staff. Staff member #11 indicated staff did not keep a temperature log, but staff members #12 and #13</p> | | <p>2/26/15 The dispenser was removed and moved away from electrical switch (Attachment A S1118)</p> <p>2/26/15 Education from Plant Manager to Plant staff regarding hand sanitizer placement. Education included facility policy and regulatory agency guidelines on issue. (Attachment B- S1118)</p> <p>2/26/15 Alcohol based hand dispenser placement will be an additional review piece during weekly EOC rounds by Plant Manager.</p> <p>3/26/15 EOC voted to add tracking of alcohol-based hand dispensers to Hazardous Surveillance Form. (Attachment C & D- S1118)</p> <p>4/8/16 Reminder of appropriate placement of alcohol based hand dispenser will be presented at the next Leadership meeting.</p> <p><u>Blanket/Fluid Warmers:</u></p> <p>3/20/15 Policy developed based on national practice standards and AORN guidelines. Policy approved by VP of Patient Care. (Attachment E -S1118)</p> <p>3/20/15 Education summary including policy and temperature log details were provided to Clinical Leaders related blanket/fluid warmers. (Attachment F-S1118). The clinical leaders from each respective area are responsible to educate staff on policy implementation and temperature tracking.</p> <p>3/23/15 New policy and process</p> | | | | |

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| | <p>indicated it was policy to keep a temperature log.</p> <p>3. During the tour of the C/S (Cesarean Section) operating room #2 at 2:20 PM on 02/23/15, accompanied by staff member #28, a unit nurse, a Steris warmer was observed with blankets, wrapped mom packs, and one 1000 ml. (milliliter) bag of Lactated Ringer's solution. The fluid was not date marked. The temperature logs indicated, "IV solution temperature should not exceed 104 degrees F. Irrigating solution temperature should not exceed 150 degrees F." The form did not mention a temperature for blankets or wrapped packs.</p> <p>4. During the tour of Birthing Room #6 at 2:35 PM on 02/23/15, accompanied by staff member #27, the unit manager, a Steris warming unit was observed containing blankets and one 1000 ml. container of normal saline irrigation fluid. The fluid was not date marked. The temperature log indicated the range for the blanket warmer was 125- 135 degrees F and to notify the maintenance department as soon as possible if it was not in acceptable range. The log for February 2015 indicated the temperature was 150 degrees on 02/01/15 and 145 degrees on 02/2/15 through 02/09/15, but</p> | | <p>discussed at Leader Rounding 4/21/15 Education related to blanket/fluid warmer policy and process will be presented at Shared Governance and up through Unit Councils. How are you going to prevent the deficiency from recurring in the future? <u>Alcohol based dispenser:</u> Tracking of appropriate placement will be monitored through EOC weekly rounding by Plant Manager as well as through Hazardous Surveillance surveys done housewide.</p> <p><u>Blanket/Fluid Warmers:</u></p> <ol style="list-style-type: none"> Tracking will be maintained through review of warmer temperature logs. These logs will be maintained on each respective unit. The monthly summary of performance for areas will be forwarded up to Quality Steering Committee, reviews will continue for 3 months and be re-evaluated to determine if further action is needed or if tracking may be discontinued. Report to QSC 5/5/15 (Attachment G-S1118) Who is responsible: Rhonda Smith, VP Pt Care Services Date Completed: 4/21/15 | |

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| | <p>no indication that the maintenance department had been notified or any other action taken.</p> <p>5. During the tour of the Out-Patient Surgery Center at 12:55 PM on 02/25/15, accompanied by staff members #23, the OR Systems Director, #46, the center manager, and #47, the pre-post supervisor, a Steris warmer was observed containing blankets and registering 125 degrees F. Staff member #47 indicated staff did not keep a monitoring log.</p> <p>6. During the tour of the surgical area of the Out-Patient Surgery Center at 1:30 PM on 02/24/15, accompanied by staff members #46 and #48, the OR supervisor, a Steris warmer was observed containing only blankets, with the top chamber registering 104 degrees F and the bottom chamber registering 142 degrees. Staff member #48 indicated irrigation solutions were sometimes also placed in the warmer and indicated there were no temperature monitoring logs.</p> <p>7. During the tour of the holding area of the Out-Patient Surgery Center at 1:40 PM on 02/24/15, accompanied by staff members #46 and #48, a Blickman blanket warmer was observed registering 140 degrees F and with no temperature monitoring logs.</p> | | | |

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| | <p>8. At 2:30 PM on 02/24/15, staff member #2, the VP and CNO (Chief Nursing Officer), indicated the facility followed AORN (Association or periOperative Nurses) guidelines and provided association documentation which indicated warming temperatures for blankets or other patient linens should not exceed 130 degrees F. The documentation also indicated solutions, blankets, and patient linens should be stored in separate warming cabinets or in separate compartments with independent temperature controls and temperatures should be set, maintained, monitored, and documented according to organizational policy. Staff member #2 confirmed the facility did not have a policy for warming blankets and fluids and confirmed different temperature logs were being used throughout the facility.</p> <p>9. Documentation from the facility's fluid manufacturer, Hospira, was provided by staff member #2 which indicated fluids for IV use could be warmed to a temperature of 104 degrees F for a period of only 14 days and irrigation fluids could be warmed to 150 degrees F, but only for 24 hours.</p> <p>10. The manuals for the various warming units were provided by staff member #2</p> | | | |

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| S 164 Bldg. 00 | <p>and all indicated that liquids in non-vented closures should not exceed 150 degrees F, but instructed manufacturer recommendations be followed. They all listed the temperature ranges, but did not give recommended temperatures for any items and indicated any items in the warmer could be a burn hazard.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and staff interview, the hospital failed to ensure a risk assessment was performed on a gamma camera for scheduling the routine preventive maintenance.</p> <p>Findings included:</p> | S 164 | <p>How are you going to correct deficiency? 1. On 3/3/15 and 3/19/15- AVI Diagnostics Services Inc provided diagnosis and service of complete PM for all four gamma cameras. (Attachment A under S1164). 2. No historical data available at time of camera purchase. Referred to manufacturers recommended guidelines to establish PM and testing intervals- Contracted with AVI Diagnostics to provide PMs and inspections of gamma</p> | 04/23/2015 |
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| | <p>1. Union Hospital Terre Haute Medical Equipment Management plan policy #227 (last reviewed 4/2013) indicated all equipment or types of equipment used for diagnosis, treatment, monitoring, and care of patients and other fixed and portable, electric-powered equipment must be evaluated using a point system for each of the criterion. Maintenance will work with department managers to assess the following risk factors to determine the preventive maintenance schedule.</p> <p>2. Documentation that was provided evidenced that the Nuclear Medicine Department was a contracted service until 2/28/2014. Union Hospital Terre Haute bought the leased space and equipment that was occupied by THML1. The last preventive maintenance that THML1 conducted was 2/7/2013. The hospital staff did not provide documentation of risk assessment on the gamma camera that was</p> | | <p>cameras. (Attachment B under S1164)3. Revision to clinical equipment policy is in process-revision will include equipment inventory, risk assessments, and preventative maintenance intervals for all new acquired equipment. Policy scheduled to go to EOC meeting on April 23, 2015How are you going to prevent deficiency from recurring in the future?1. Contracted with AVI diagnostics for completion of annual PMs. 2. Added the four camera PMs to the master listing of Quarterly Radiation Safety QA survey. (Attachment C under 1164 see pg 5 highlighted areas). Who is responsible:Jack Hill, COOCompletion Date: April 23, 2015</p> | |

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| NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1606 N SEVENTH ST TERRE HAUTE, IN 47804 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>purchased by the hospital on 2/28/2014 and there was no documented preventive maintenance conducted by the hospital.</p> <p>3. At 10:30 AM on 2/25/2015, staff member #5 (Maintenance Manager) indicated the hospital has never conducted a routine preventive maintenance on any patient care equipment located in the Nuclear Medicine Department after the hospital bought the equipment on 2/28/2014. The staff member indicated there was no risk assessment performed on the equipment either.</p> | | | | |