

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150101	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER PARKVIEW WHITLEY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1260 E SR 205 COLUMBIA CITY, IN 46725
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 9/8/2014 through 9/10/2014</p> <p>Facility Number: 005090</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 09/23/14</p>	S000000		
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 observation and interview, the facility failed to ensure a safe</p>	S000554	<p>WHO: The deficiencies cited</p>	09/29/2014

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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	<p>environment for patients by ensuring clean supplies and equipment were protected from contamination in patient care areas.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the Emergency Department at 8:40 AM on 09/09/14, accompanied by staff members A1, the VP of Patient Care, A3, the Quality Accreditation Specialist, and A12, the ED Manager, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies in the clean supply room. At 8:45 AM on 09/09/14, staff members A1 and A12 confirmed the risk of cross-contamination to clean supplies from the outside shipping containers. During the tour of the Med/Surg Unit at 9:40 AM on 09/09/14, accompanied by staff members A1 and A13, the In-Patient Supervisor, cardboard shipping boxes were observed stored on open metal shelves alongside open, clean supplies in the clean supply room. At 9:45 AM on 09/09/14, staff members A1 and A13 confirmed the risk of cross-contamination to clean supplies from the outside shipping containers. 		<p>within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report.</p> <ul style="list-style-type: none"> The VP of Patient Services and Manager of Site Distribution are ultimately responsible for the corrective action and for overall and ongoing compliance. <p>WHAT: Concisely describe the actions completed. Contents in outside corrugated shipping containers will be emptied into plastic bins. The bins will be taken to the departments for distribution of supplies.</p> <p>WHEN: Please indicate the dates each action was completed. 9/9/2014 – VP of Patient Services met with Manager of Site Distribution to discuss process of outside shipping containers delivery to departments. 9/29/2014 – Plastic bins ready for delivery to departments.</p> <p>HOW: Please describe how compliance will be sustained. Once per month, for the next year, leaders will audit supply areas to ensure outside corrugated shipping containers are not stored with clean supplies. Audit results will be tracked and trended on the</p>	

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S000596	<p>5. During the tour of the Obstetrical Unit at 11:00 AM on 09/09/14, accompanied by staff members A1 and A16, the Family Birthing Center Supervisor, cardboard shipping boxes were observed stored on the top open shelf above open, clean supplies in the storage room.</p> <p>6. At 11:10 AM on 09/09/14, staff members A1 and A16 confirmed the risk of cross-contamination to clean supplies from the outside shipping containers.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p>		Measures of Success (MOS) Dashboard. Compliance will be reviewed quarterly at Patient Care Committee. Compliance issue will be referred to administration for resolution.	

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	<p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on documentation review and staff interview, the facility failed to ensure Radiology Department's ultrasound medical devices were rinsed off thoroughly of Cidex OPA as required by the manufacturer's specifications and per hospital policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for semi-critical devices. Cidex OPA manufacturer sheet required for manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done. Infection Prevention policy (last 	S000596	<p>WHO:</p> <ul style="list-style-type: none"> The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. Infection Prevention and the Radiology Manager are ultimately responsible for the corrective action and for overall and ongoing compliance. <p>WHAT: Concisely describe the actions completed.</p> <ul style="list-style-type: none"> Update Cleaning & Disinfection Policy will reflect in lieu of 3 immersion rinse baths, the transvaginal ultrasound probe will be rinsed under tap water for a minimum of two minutes (4 gallons/minute) Staff competency will specifically state 2 minute rinse. Staff competency as well as review of the policy will be completed with all staff that perform this procedure. <p>WHEN: Please indicate the dates each action was completed.</p> <p>First 30-days (10/8/2014 to 11/8/2014)</p> <ul style="list-style-type: none"> 9/29/2014- Staff competency revision complete 10/15/2014- Policy 	11/08/2014

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	<p>approved 12/2013) stated, "Following immersion in CIDEX Solution, thoroughly rinse the equipment or medical device by immersing completely in three copious volumes of water. Each rinse should be a minimum of 1 minute in duration unless otherwise noted in department policy. Use fresh portions of water for each rinse. Discard the water following each rinse."</p> <p>3. At 1015 on 9:10/2014, Radiology Technician staff member #17 explained the process of rinsing off the ultrasound's vaginal probes of CIDEX OPA. The staff member would disinfect ultrasound's vaginal probes in the Central Sterile department decontamination room. After medical devices have been processed in CIDEX, the device would be held under running water of the sink's faucet for a minute or two. The staff member indicated the procedure in the Radiology Department does not specify how</p>		<p>reviewed and approved with update by Infection Control Committee</p> <p>· 10/31-2014- Staff competency and policy review with staff that perform this procedure.</p> <p>HOW: Please describe how compliance will be sustained. All staff who complete cleaning and disinfection of a transvaginal ultrasound probe will be mandated to satisfactorily complete an annual competency related to this procedure.</p>	

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S000726	<p>to rinse off medical devices that been processed in CIDEX OPA. The staff member indicated he/she has never read the Infection Prevention policy on processing medical equipment in CIDEX OPA.</p> <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 policy and procedure review, observation, and interview, the facility failed to protect patient medical records from unauthorized access in the</p>	S000726	<p>WHO:</p> <p>The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the</p>	09/24/2014

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	<p>Out-Patient Surgery area.</p> <p>Findings included:</p> <p>1. The facility policy "Medical Records", last reviewed 02/2014, indicated, "C. Authority, Security, and Responsibility: ...2. The medical record shall be considered the property of the healthcare facility, which shall seek to safeguard it from unauthorized use, access, loss, or destruction. ...3. The original medical record whether captured in paper or electronic form, shall be protected and used for patient care and Parkview Hospital business purposes based on need to know.</p> <p>2. During the tour of the Out-Patient Surgery area at 2:00 PM on 09/08/14, accompanied by staff members A1, the VP of Patient Care, and A8, the Surgical Services Manager, patient medical records were observed stored on open, built-in shelves in the nurses' station. The shelves had no door or any way to secure the contents after hours.</p> <p>3. At 2:10 PM on 09/08/14, staff member A8 indicated the unit was locked after hours; however, he/she acknowledged the housekeeping staff cleaned the area during that time without surgery services staff present. He/she</p>		<p>President, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report.</p> <p>The Surgery Manager is ultimately responsible for the corrective action and for overall and ongoing compliance.</p> <p>WHAT: Concisely describe the actions completed. Patient medical records will be secured from unauthorized access in the Out-Patient Surgery Area</p> <p>WHEN: Please indicate the dates each action was completed. 9/24/14 – Patient medical records are locked in secured area after scheduled hours of operation.</p> <p>HOW: Please describe how compliance will be sustained:</p> <p>The Surgery Manager and staff will complete daily checks that medical records are secured prior to closing of department. On a quarterly basis, this area will be audited for compliance with environmental rounding.</p>				

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S000952	<p>indicated all staff were the facility's employees and received HIPAA training.</p> <p>4. At 2:15 PM on 09/08/14, staff member A1 confirmed the medical records stored on the open shelves would be accessible to the housekeeping staff who were not classified as "need to know" personnel.</p> <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 physician orders and policy were followed regarding blood transfusions for 1 of 1 patients with specific time parameters for the transfusions (N28).</p> <p>Findings included:</p> <p>1. The facility policy "Blood and Blood Component Administration", last</p>	S000952	<p>WHO:</p> <ul style="list-style-type: none"> The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. VP of Patient Services is ultimately responsible for the corrective action and for overall 	01/08/2015

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	<p>reviewed 07/2014, indicated, "13. Once the initial 15 minutes of the transfusion is complete: ...d. Adjust the rate of transfusion according to MD order or per component specific recommendation."</p> <p>2. The medical record for patient N28, an 93-year old admitted 06/14/14 with a diagnosis of anemia and shortness of breath and with a history of CHF (congestive heart failure), indicated a physician order from 06/15/14 for 2 units of packed red blood cells, each unit to be transfused over 4 hours. The record indicated the first unit was started at 1036 on 06/15/14 and completed at 1313 on 06/15/14, two hours and 37 minutes later. The second unit was started at 1350 on 06/15/14 and completed at 1635 on 06/15/14, two hours and 45 minutes later.</p> <p>3. At 12:30 PM on 09/10/14, staff member A13, the In-Patient Supervisor, who was reviewing the records on the electronic system, confirmed the transfusions were not administered according to physician orders.</p>		<p>and ongoing compliance.</p> <p>WHAT: Concisely describe the actions completed.</p> <ul style="list-style-type: none"> · Inpatient Supervisor/Department Managers will provide education to department nurses via reference guide (cheat sheet) regarding blood transfusion process with particular emphasis on confirming transfusions are administered according to physician orders. · Blood transfusion documentation audits will be performed for 100% of blood transfusions for 90 days. <p>WHEN: Please indicate the dates each action was completed.</p> <p>First 30-days (10/8/14 to 11/8/2014)</p> <ul style="list-style-type: none"> · 10/2/2014 - Inpatient Supervisor/Department Managers will educate all nurses on blood transfusion process by review of policy and use of reference guide. · Audit to be completed on 100% of units given by Inpatient Supervisor/Department Managers for 90 days. <p>Second 30-days (11/8/2014 to 12/8/2014)</p> <ul style="list-style-type: none"> · Transfusion audits will be completed by the Inpatient Supervisor/Department Managers for 100% of the units transfused for 90 days. <p>Third 30-days (12/8/2014 to 1/8/2015)</p> <ul style="list-style-type: none"> · Transfusion audits will be completed by the Inpatient Supervisor/Department Managers for 100% of the units transfused 	

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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 hospital failed to maintain the environment and equipment in such a manner that the safety and well-being of staff are assured in EVS (environmental</p>	S001118	<p>for 90 days.</p> <p>HOW: Please describe how compliance will be sustained. To ensure ongoing compliance of the blood transfusion process, a sample of transfusion records (a minimum of 3) will be reviewed and validated against the transfusion policy. Audit results will be tracked and trended on the Measures of Success (MOS) Dashboard. Compliance will be reviewed at Patient Care Committee. Compliance issue will be referred to administration for resolution.</p> <p>WHO: The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and</p>	10/10/2014

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	<p>services) Main Storage.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The 2014 Safety Management Plan objectives are to maintain a safe environment for patients, staff and visitors. The plan notes the hospital is to comply with all federal, state, and local laws and regulations. These regulations include: OSHA, ISDH, Life Safety Code. 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. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 		<p>implement a plan of correction to address and clarify the findings as listed in the report.</p> <ul style="list-style-type: none"> The Manager of Facilities is ultimately responsible for the corrective action and for overall and ongoing compliance. <p>WHAT: Concisely describe the actions completed. An Eye wash station will be installed in EVS Main Storage room.</p> <p>WHEN: Please indicate the dates each action was completed. 9/29/2014- Eye wash station purchased. 10/10/2014- Eye wash station installed in EVS Main Storage room.</p> <p>HOW: Please describe how compliance will be sustained. The hospital Facilities Department shall be responsible for the annual inspection and testing of the eyewash station as per facility policy.</p>	

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S001162	<p>7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>3. At 1030 on 9/29/2014, the EVS Main Storage room was toured. The room contained 14 5-gallon pails of floor wax that require 15 minutes of continuous eye flushing with water if the chemical comes in contact with a person's eyes. The room also contained an industrial automatic scrubber that had two 12-volt batteries within it that contain corrosive acid. The room was observed without an eye wash station for staff safety if the chemical or the corrosive acid would come in contact with a person's eyes.</p>			
	410 IAC 15-1.5-8			

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	<p>PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on documentation review and observation, the hospital failed to comply with manufacturer recommendations for 2 of 2 Hydrocollators located at Physical Rehabilitation Department.</p> <p>Findings included:</p> <p>1. The Operation Manual instructions for the use and operation for Chattanooga Hydrocollators: M-4 and SS-2; Operating Temperature for all models is 160 to 166 degrees Fahrenheit.</p>	S001162	<p>WHO:</p> <ul style="list-style-type: none"> The deficiencies cited within this survey report were reviewed via in-person meetings by senior leadership including the President, VP of Patient Services and Department Managers. As a result of this review, a directive was issued to develop and implement a plan of correction to address and clarify the findings as listed in the report. The Manager of Rehab Services is ultimately responsible for the corrective action and for overall and ongoing compliance. <p>WHAT: Concisely describe the actions completed. The Operating Temperature for all models is 160 to 166 degrees Fahrenheit.</p> <p>WHEN: Please indicate the dates each action was completed The log was updated on 9/11/2014 to reflect accurate</p>	09/11/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150101	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/10/2014
NAME OF PROVIDER OR SUPPLIER PARKVIEW WHITLEY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1260 E SR 205 COLUMBIA CITY, IN 46725		
(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	
	2. At 1120 on 9/11/2014, the Physical Rehabilitation Department was observed with Chattanooga M-4 and SS-2 model Hydrocollators. The temperatures were recorded daily. The Hydrocollator logs noted that the temperature needs to be between 158 and 166 degrees Fahrenheit and temperatures on both units were recorded below 160 degrees Fahrenheit more than 90% of the time.		operating temperature. HOW: Please describe how compliance will be sustained. The Manager of Rehabilitation Services will document annual review of the manufacturer guidelines for each hydrocollators model in use on the Measures of Success Dashboard.		