

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150010	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
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NAME OF PROVIDER OR SUPPLIER ST JOSEPH HOSPITAL & HEALTH CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1907 W SYCAMORE ST KOKOMO, IN 46904
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S0000	<p>This visit was for a State hospital survey.</p> <p>Dates: 10/16/2012 through 10/18/2012</p> <p>Facility Number: 005010</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 11/09/12</p>	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on document review and staff interview, the facility failed to comply with all applicable state laws for 1 unlicensed nursing assistant employee files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. During the review of staff member #33 personnel file, the CST was not certified nor licensed 	S0102	<p>As of November 16, 2012, we are checking the nurse aide registry upon hire for all unlicensed/uncertified staff, which will include all clinical and non-clinical staff. The pre-employment checklist has been updated to reflect this change. The policy has been updated to ensure this process remains in effect. To assure compliance is maintained with the new process; 4 random new employee files will be audited quarterly by Quality. The audits will continue until there is documented 100% compliance for 2 quarters. Executive director of Human Resources is responsible.</p>	11/16/2012	

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	<p>to provide health care. The staff member was hired in 12/6/2010 for another position that did not require direct patient care; however, the staff member was transferred to a position of a CST on 11/13/2011. The facility failed to run a nurse aide registry check on staff member #33.</p> <p>3. At 2:00 PM on 10/18/2012, staff member #13 indicated staff member #33 was transferred to the position of a CST and has a year to get his/her certification.</p>				

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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 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 staff interview, the facility failed to ensure 7 hospital services were submitted to the Governing Board for review as defined in the 2012 Patient Safety & Performance Improvement Plan.</p> <p>Findings included:</p> <p>1. The 2012 Patient Safety & Performance Improvement Plan states, "Facilitating documentation and reporting of performance improvement activities to the Board of Directors. The Board of Directors will annually review and identify organizational improvement opportunities that will provide the focus for performance improvement activities for the hospital."</p>	S0270	<p>On November 15, 2012, the lack of quality reporting was shared with the Hospital Board of Directors, and it was determined that all hospital services quality reports will be shared with the Board of Directors on a quarterly basis for their review and evaluation. All hospital services will be displayed and monitored using a quality dashboard. The quality reports for Ambulance Services, Bioengineering, Housekeeping, Infusion Therapy, Laundry/Linen, Renal Dialysis, and Sleep Lab Services will be reported to the Board of Directors, at their next meeting on 1/24/13. This will be included in the Board of Director minutes at least quarterly. Executive Director of Medical Affairs and Quality is responsible.</p>	01/24/2013	

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	<p>2. The Board of Director meeting minutes were reviewed between 7/28/2011 and 6/28/2012. The Board meeting minutes did not evidence that the following hospital services were brought to the board for quality assurance review and evaluation: Ambulance Services, Bioengineering, Housekeeping, Infusion Therapy, Laundry/Linen, Renal Dialysis, and Sleep Lab.</p> <p>3. At 1:15 PM on 10/18/2012, staff member #2 indicated Ambulance Services, Bioengineering, Housekeeping, Infusion Therapy, Laundry/Linen, Renal Dialysis, and Sleep Lab services had not been provided to the Governing Board of Directors for their review.</p>				

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure Ambulance and Sleep Lab services were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The 2012 Patient Safety & Performance Improvement Plan indicated all patient care service provided by the hospital are to be evaluated by the Patient Safety & Quality Committee. 2. The Patient Safety & 	S0406	The Ambulance Service and the Sleep Center will report quality data to the Patient Safety & Quality Committee of the hospital for review and evaluation at the next meeting on 11/28/12.All hospital services will be displayed and monitored using a quality dashboard.This data will be included in the Patient Safety & Quality Committee minutes at least annually.The Executive Director of Medical Affairs and Quality is responsible.	11/28/2012			

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	<p>Performance Improvement committee data revealed that Ambulance and Sleep Lab Service were not being evaluated.</p> <p>3. At 1:15 PM on 10/18/2012, staff member #2 confirmed that Ambulance and Sleep Lab services were not being evaluated by the Patient Safety & Performance Improvement Committee.</p>			

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on policy and procedure review, observation, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Emergency Crash Carts", last revised 01/2010, indicated, "...9. Central Supply Department will maintain control of the sterile supplies on each crash cart. On a monthly basis, CS staff will check the expiration dates of supplies on each cart in the hospital." During the tour of the Emergency Department at 10:05 AM on 10/17/12, accompanied by staff members #P1, P4, and P18, the following expired items were observed: <ul style="list-style-type: none"> A. A pediatric endotracheal tube, expiration date 11/2007, in the cabinet in the trauma room. B. A suction catheter, expiration date 03/2008, in the cabinet in the trauma room. 	S0554	<p>On 10/18/12, all crash carts in the facility were checked for supplies expired or expiring within one month and restocked. Central Processing Team Leader was educated on the process and policy for checking and restocking crash carts on 10/18/12. Monthly checks of every code cart are to be done by Central Processing and replaced as necessary. Crash cart check lists were redesigned to have individual areas check daily for date of first expiring item. These were placed on the crash carts and educated to staff on 10/18/12. This will serve as a double check for central processing. ICU team lead will verify monthly checks are completed and will spot check at least 4 carts per month throughout the hospital to verify that monthly and daily checks are completed. The Director of Emergency/Critical Care Services is responsible. All supplies on units were checked for expiration dates. All medical supplies on units will be monitored monthly for expiration date. All supplies in the materials supply room will be monitored by the supply materials</p>	11/15/2012			

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	<p>C. A BD Insyte Autoguard 16 gauge catheter, expiration date 12/2011, in the difficult airway kit.</p> <p>3. During the tour of the Obstetrical Department at 11:40 AM on 10/17/12, accompanied by staff members #P1, P4, and P20, a 250 milliliter bag of 10% Dextrose intravenous fluid with an expiration date of 1 Sept. 12 was observed on the pediatric crash cart.</p> <p>4. During the tour of the Behavioral Health Unit at 1:15 PM on 10/17/12, accompanied by staff members #P1, P4, and P22, the following expired items were observed on the crash cart: A. An Arrow Central Line kit, expiration date of 05/2012. B. A Betadine Scrub Care kit, expiration date of 03/2012.</p> <p>5. During the tour of the 2 Medical/Pediatric Unit at 2:25 PM on 10/17/12, accompanied by staff members #P1, P4, and P23, a 6-pack of Enfamil Prosobee infant formula with an expiration date of 1 Oct. 12 was observed in a cabinet in the pantry. Staff member #P23 indicated the formula should not be stored in the pantry.</p> <p>6. At 2:30 PM on 10/17/12, staff members #P1 and P4 indicated the staff</p>		<p>department and checked monthly for outdates. Any supply that is removed from the supply room and stored in a patient care area will be the responsibility of the nursing staff. Checking supplies will be assigned using a monthly check list/assignment sheet and will be signed when completed. This check list will be monitored by the Nurse Manager or Team Lead. The Vice President of Nursing is responsible.</p>				

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	from Central Supply should check for outdated supplies, both on the crash carts and on the units, but could not provide documentation of these checks.			

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S0596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on policy and procedure review, manufacturer's recommendations, training records, and interview, the infection control committee failed to ensure the patient care areas were cleaned and disinfected according to policy.</p> <p>Findings included:</p> <p>1. Review of the facility's housekeeping policies and procedures indicated numerous policies for the various areas of the hospital with conflicting directions for cleaning. The facility policy "Sub-Critical: Patient Room Cleaning", last revised 04/2011, indicated, "Material Recommended: Disinfectant, cream cleanser, all purpose cleaner, window cleaner. ...1. Furniture in patient room</p>	S0596	<p>One new Touchpoint policy was approved on 11/16/12 for Housekeeping Cleaning & Disinfecting in patient care areas, and replaced the multiple polices on cleaning that were discovered and contradict each other. The policy has been educated to staff and has been posted for all staff to read. A new process for Environmental Services Policies (EVS) has been developed. All EVS policies related to patient care will be sent to the Infection Control Committee for approval. All Environmental Services staff have been re-educated on the use of disinfectant. Training is documented in department meeting minutes and department huddle notes.</p>	11/30/2012			

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	<p>should be damp dusted with clean cloth, using germicidal solution. ...8. Damp mop patient room floor starting in the same far corner."</p> <p>The facility policy "Team Responsibilities in Patient Room Cleaning", last revised 11/2010, indicated, "...General Patient Room Cleaning: ...3. Cleaning and disinfecting the patients bed ...7. Disinfect the pillows ...9. Disinfectant all furniture 10. Clean sink and plumbing ...16. Bathroom stool and shower ...18. Dust mop and wet mop floors." Policies for isolation cleaning and cleaning critical care areas and the nursery specified cleaning the bathrooms and floors with a germicidal solution.</p> <p>2. The manufacturer's instructions for some of the products used for cleaning, Diversey Stride HC, GP Forward, and Emerel cream cleanser, listed the cleaning properties of the products, but did not specify any disinfectant properties or any organisms that would be killed by the products.</p> <p>3. Review of the housekeeping training guide indicated the following regarding the products used: A. Directions for Virex 256, the disinfectant product used, indicated the product was safe to use on all patient</p>		<p>Direct observation competency program for all staff was developed on 11/14/12.</p> <p>Direct cleaning observations of all staff based on the new policy started 11/15/12 and are being incorporated into routine audits completed every two weeks. Every associate will have their first observation completed by 11/30/12.</p> <p>To ensure continued compliance- annual assessments based on direct observation will be completed on an annual basis prior to yearly evaluations and will be done on each associate.</p> <p>Monthly rounds for direct observation have been scheduled with EVS Manager, IC Practitioner, and Executive Director.</p> <p>The Executive Director of Support Services is responsible.</p>				

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	<p>contact surfaces, including tile flooring. A note indicated the germicide must dwell on the surface for 10 minutes for maximize disinfection and should not be wiped dry.</p> <p>B. Directions for the Emerel cream cleanser indicated the product should be used sparingly and required considerable rinsing. A note indicated extensive use of the product could damage porcelain and was not intended for daily use.</p> <p>4. The "Employee Training Tracker" record was provided by staff member #P28 at 4:30 PM on 10/17/12 to indicate training of housekeeping staff. The record listed various topics of education with dates of the training. The topics "Isolation Room Cleaning", "C-Diff", and "10-Step Cleaning" lacked documentation of training for 41 of the 49 staff members on the list.</p> <p>5. During the tour of the 2 Medical/Pediatric Unit on 10/17/12, housekeeping staff member #P24 was interviewed. He/she indicated the routine room cleaning consisted of using Emerel in the bathroom, GP Forward in the water to mop the floor, and a Virex solution to wipe all the surfaces and bed in the room. He/she indicated he/she wiped the surfaces with a rag from the Virex, waited about 10 minutes, then wiped to remove</p>						

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	<p>any streaks. He/she indicated the same products were used on an occupied or unoccupied room.</p> <p>6. At 1:30 PM on 10/18/12, the manager of environmental services, staff member #P28, indicated the housekeeping services became a contracted service on 03/17/12, but all of the previous employees kept their original hire date. New education was provided because of some new products and procedures implemented. He/she confirmed the lack of training in some areas for some of the staff, but indicated training in those areas had been provided originally, but could not provide documentation of that training. He/she confirmed the record lacked documentation of any training for staff member #P24, the housekeeper interviewed, who had been hired 04/16/2009.</p> <p>Staff member #P28 indicated he/she interviewed 10 housekeeping staff members this morning and asked them to describe their cleaning procedure. He/she indicated the staff used the rag with the Virex solution, along with the Emerel, to clean the bathrooms so they would be disinfected. He/she acknowledged the products would no longer be used according to manufacturer's instructions and with mixing and rinsing, disinfection</p>						

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	<p>could no longer be assured. He/she felt confident in the staff's training, but confirmed documentation did not support this.</p> <p>7. At 1:40 PM on 10/18/12, staff members #P1 and P6 confirmed the confusion with all of the housekeeping policies and improper use of chemicals.</p>			

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S0612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on observation, the facility failed to provide a clear separation of soiled and clean linen in the housekeeping laundry room.</p> <p>Findings included:</p> <p>1. At 2:00 PM on 10/17/2012, the Housekeeping Laundry Room was inspected. The room had a washer and dryer located at the far end of the room. On the right side of the room, there were 4 white uncovered storage containers holding clean fiber mop heads and linen rags that are used in patient rooms. The left</p>	S0612	<p>Beginning 11/17/12 all mop heads and rags will be sent to North Central Indiana Linen Services for cleaning.</p> <p>The washer and dryer room in the Environmental Services Department was closed 11/16/12. It will remain closed until construction can be completed to meet State guidelines.</p> <p>The Executive Director of Support Services is responsible.</p>	11/17/2012

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	<p>side of the room was observed with uncovered containers of soiled linen that were used in patient rooms.</p> <p>2. At 2:15 PM on 10/17/2012, staff member #3 did not realize the hospital had a laundry room that was being operated by their contracted housekeeping company. The staff member confirms there could be a cross contamination concern between soiled and clean linen storage.</p>			

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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on medical record review, policy and procedure review, and interview, the registered nurse failed to ensure the admission policy was followed for 2 of 2 pediatric records reviewed (#N9 and N10).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The medical record for patient #N9, a 14-month old infant admitted 09/12/12, lacked documentation of measurement of a head circumference with the admission assessment or any time prior to discharge on 09/14/12. The medical record for patient #N10, a 14-month old infant admitted 02/29/12, lacked documentation of measurement of a head circumference with the admission assessment. This measurement was recorded two days later on 03/02/12. The facility policy "Admission of Patient and Patient Health Profile", last revised 04/2011, indicated, "...2. The RN 	S0930	<p>All pediatric staff were re-educated at the November staff meeting about what the pediatric assessment policy states. Appropriate policy already in place.</p> <p>An admission checklist will be placed with every admission packet. The checklist is to be completed on every admission as a reminder of what is required.</p> <p>Manager now receives a computer generated list of pediatric patients and will be auditing charts for required documentation. A report will be submitted to the quality team and will be reviewed at the Patient Safety & Quality Committee.</p>	11/16/2012			

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	<p>(Registered Nurse) is responsible for the completion of the Patient Health Profile form within the time frame established by hospital policy and standards of care of each nursing unit. ...Pediatrics: The nurse will greet and begin a preliminary assessment within 30 minutes of patient arrival to the pediatric unit. The patient health profile and assessment will be completed within four hours of admission to the unit. ...16. On Pediatric Admission Assessment ONLY- Head Measurement is completed on children 18 months and younger."</p> <p>4. At 1:00 PM on 10/18/12, staff member #P4, who navigated the EMR (Electronic Medical Record), confirmed the lack of adherence to the admission policy.</p>		The Manager of the Pediatric Unit is responsible.		

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy review, medical record review, and interview, the facility failed to ensure blood transfusions were administered according to facility policy, physician orders, and standard of practice for 3 of 5 patients who received blood transfusions (#N4, N7, and N8).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Blood and Blood Component Administration", last revised 03/2012, indicated, "...3. Take a complete set of vital signs within one hour of administration of each unit of blood." The medical record for patient #N4 indicated pre-infusion vitals signs were taken at 0910 on 08/01/12, but the unit of blood was not started until 1111, two hours later. The medical record for patient #N7 	S0952	<p>A memo was posted in all patient care areas where transfusions occur and sent via email to all nursing staff on November 16, 2012. This memo reiterated the requirements of the hospital's Blood and Blood Product Administration Policy as well as the requirements to document thoroughly all patient care that is performed. Staff was reminded to document any reasons for a delay in blood product administration or medication administration.</p> <p>Auditing will commence immediately to assess compliance with the Blood and Blood Product Administration Policy as</p>	11/16/2012			

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	<p>indicated a physician order from 1040 on 08/07/12 for T & C (Type and Crossmatch) for 2 units of PRBCs (Packed Red Blood Cells), transfuse both, and give Lasix 10 mg. (milligrams) intravenously between units. The blood bank report indicated the blood was ready at 1330. The first unit of blood was started at 1725 and the time for the pre-transfusion vitals signs was written over/changed to 1720. The record indicated the unit was completed at 2039 and the patient was transferred to another facility at 2040. The record lacked documentation of the Lasix being given or any other documentation regarding why the Lasix wasn't given, why the remaining unit of blood wasn't given, orders from the physician to not carry out the original orders, or instructions from the receiving facility to hold the Lasix or blood.</p> <p>4. The medical record for patient #N8, who came to the hospital specifically to receive blood for a diagnosis of anemia and menorrhagia, indicated a physician order from 1255 on 08/12/12 for 3 units of PRBCs to be transfused with Lasix 10 mg. to be given after the first and second units. The lab report from 1237 on 08/12/12 indicated the patient's hemoglobin was 6.5 (normal 12.4- 15.2) and the hematocrit was 23.2 (normal</p>		<p>well as the requirement to document thoroughly all blood transfusions that are administered. This will be reported to the Patient Safety & Quality Committee.</p> <p>The Vice President of Nursing Services is responsible.</p>				

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	<p>37.0- 45.2) and the blood was ready at 1325. The record indicated the first unit was started at 1553 and completed at 1925, but the Lasix wasn't given until 2114, almost 2 hours after completion. The second unit of blood wasn't started until 2303, over 3 and one half hours after completion of the first unit. The second unit was completed at 0135 on 08/13/12 and the Lasix was given at 0140. The third unit was started at 0200 on 08/13/12 and completed at 0450. The record lacked any documentation to explain the long delay between the first and second units of blood or the delay in administering the Lasix after the first unit.</p> <p>5. At 11:00 AM on 10/18/12, staff member #P4, who was navigating the EMR, confirmed the findings and indicated there should have been some documentation to explain the time delays on patient #N8 since her hemoglobin and hematocrit were so low. He/she indicated he/she was familiar with patient #N7, the patient who was transferred, and remembered that the second unit of blood was not given at the request of the receiving facility because they did not want it infusing enroute. He/she confirmed the lack of documentation explaining this or whether or not the physician was aware.</p>			

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S1014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on observation, policy and procedure review, and interview, the facility failed to follow its pharmacy policy regarding multidose medications and vials in three patient care areas (Emergency Department, Obstetrical Department, and Surgery).</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the Emergency Department at 10:05 AM on 10/17/12, accompanied by staff members #P1, P4, and P18, the following observations were made in the clean room: <ul style="list-style-type: none"> A. An open, but not dated, 50 milliliter vial of Lidocaine on the OB cart. B. An open, but not dated, 50 milliliter vial of Bupivacaine on the I & D (Incision & Drainage) cart. During the tour of the Obstetrical Department at 11:40 AM on 10/17/12, accompanied by staff members #P1, P4, 	S1014	<p>The Director of Pharmacy met with the Anesthesia Physicians on 11/14/12 and retrained on the requirements for labeling multi-dose vials.</p> <p>The Director of Emergency Services met with the Emergency Room physicians and retrained on the requirements for labeling multi-dose vials.</p> <p>Prefilled Ephedrine and Phenylephrine syringes have been ordered and stocked in the Birthing Center. These are needed for emergent cases. Single dose Lidocaine and Bupivacaine is stocked in the Emergency Room Pyxis and will be removed as needed.</p>	11/16/2012			

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	<p>and P20, an open, but not dated, 30 milliliter vial of Sensorcaine was observed on the epidural cart.</p> <p>3. During the tour of the Surgical Department with staff member #P26 at 3:50 PM on 10/17/12, an open 5 milliliter vial of Rocuronium was observed in the drawer of the anesthesia cart in OR #1. Two unopened vials of the medication were also in the drawer and all three vials were dated 10/9. Staff member #P26 indicated this date indicated when the medication was taken out of the refrigerator since they could only be out for 60 days. He/she indicated the date did not necessarily indicate the open date of the vial and that date should be 30 days after opening.</p> <p>4. The facility policy "Multi-Dose Injectable Vials", last revised 01/2011, indicated, "...7. Once opened, multi-dose vials must be given an expiration date of 28 days or the manufacturer's expiration date, whichever is less."</p> <p>5. A 4:15 PM on 10/17/12, staff members #P1 and P4 confirmed the findings and indicated the practice was to try to avoid the use of multi-dose vials whenever possible.</p>		<p>Quality rounds will include monitoring the labeling of multi-dose vials used by Anesthesia and the Emergency Room. The Director of Pharmacy is responsible.</p>		

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on documentation review, observation, and staff interview, the facility failed to ensure daily shift ambulance equipment/supply checks were conducted as required and failed to ensure a safe environment by monitoring the warming cabinet and fluids in the Emergency Department.</p> <p>Findings included:</p> <p>1. Seven random weeks of equipment checklist were examined on the hospital's ambulances. Each randomly selected ambulance equipment checklist has an area for 1st shift and 2nd shift to be marked if equipment was on the ambulance.</p>	S1118	<p>All EMS staff were educated by 10/26/12, on the documentation required on each ambulance every shift. The check off form (Daily Ambulance Equipment Log) was revised to include a required signature for the responsible staff member. When this form is signed the staff member attests to the fact that the ambulance is ready for service. The check lists will be monitored for completion and reported quarterly to the Patient Safety & Quality Committee. The Director of Emergency and Critical Care Services is responsible. Fluids will be warmed only in the Surgery and Day Surgery Areas. Fluids will not be warmed in the Emergency Department warmer. This is per hospital policy. All emergency department staff was educated concerning this policy. A sign was posted on the ED warmer stating no fluids in this warmer.</p>	11/16/2012			

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	<p>The results of the Daily Ambulance Equipment logs revealed only 37 shifts were checked out of 84 required shift checks.</p> <p>2. At 1:00 PM on 10/17/2012, staff member #18 indicated the EMS staff primarily operate 2 shifts. The staff member indicated each ambulance has a weekly equipment log and the supplies and equipment in each ambulance was to be checked on the ambulance for both shifts. The staff member confirmed after reviewing the ambulance equipment logs, the EMS staff were not maintaining the Ambulance Equipment Logs. The the supplies and equipment that are accountable for on the ambulances included: assorted medication, IV start kits, syringes, pressure infusion bag, etc.</p> <p>3. The facility policy "Fluid Warmer Policy", last revised 01/2012, indicated, "...Appropriate storage of warmed fluids will be the responsibility of all staff working in areas where warmed IV fluids, irrigation solutions, and radiologic contrast are stored and used. ...A. IV fluids and irrigation will be warmed using</p>		<p>Per procedure- all fluids in the warmer must be dated with a 14 day expiration date. Expiration dates will be checked daily by department nursing staff as designated by the department daily assignments.</p> <p>Quality rounds will include monitoring for expired fluids in warmers in Surgery and Day Surgery.</p> <p>The Director of Surgical Services is responsible.</p>				

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	<p>a warming cabinet only in the following areas: Surgery and Day Surgery. B. IV fluids within their plastic overwrap and bottles of irrigation solutions may be placed in a fluid warmer to be warmed to a maximum temperature of 104 degrees Fahrenheit. ...1. Fluids may be stored in the warmer for a maximum of 14 days. ...5. The IV bag or bottle of irrigation fluid must be labeled with an expiration date. This date will be 14 days after the date the fluid is placed in the warmer. ...Procedure- ...1. Do not use a marking pen directly on the IV bag, or overwrap. ...2. Once in every 24-hour period, while fluids are stored in the cabinet, an associate will be required to note the warming cabinet temperature on the log."</p> <p>4. The facility policy "Blanket Warmers", last revised 05/2011, indicated, "...2. Blankets and fluids will never be warmed in the same cabinet compartment."</p> <p>5. During the tour of the Emergency Department at 10:15 AM on 10/17/12, accompanied by staff members #P1, P4, and P18, two 1000 milliliter IV bags of 0.9% Normal Saline were observed in the top compartment of the Steris Amsco warming cabinet, along with two blankets. The date "10/9/12" was written with marker on the overwraps of the bags. The temperature of the top compartment</p>			

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	<p>registered 114 degrees Fahrenheit.</p> <p>6. At 10:15 AM on 10/17/12, staff member #P18 indicated the fluids were used infrequently for trauma patients and could be in the warmer for one week. He/she indicated no temperature checks were required, but the cabinet was usually kept under 120 degrees Fahrenheit.</p> <p>7. At 11:00 AM on 10/17/12, staff member #P19, a nurse in the Emergency Department, indicated he/she was unsure of what temperature or how long the fluids could be kept in the warmer, but thought it was a month.</p> <p>8. At 1:00 PM on 10/18/12, staff members #P1 and P4 confirmed the fluids and warmer in the Emergency Department were not managed according to facility policy.</p>				

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S1162	<p>410 IAC 15-1.5-8 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, the facility failed to ensure the Chattanooga Hydrocollator was maintained daily at the required temperature defined in the user's manual.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Chattanooga Hydrocollator Heating Unit user manual recommends the temperature to be maintained between 160 and 166 degrees Fahrenheit to maintain the integrity of the hot packs. The September temperature log 	S1162	<p>The policy for the Hydrocollator Heating Unit was updated to state that the temperature is to be maintained between 160 and 166 degrees Fahrenheit.</p> <p>TriMedix adjusted the temperature setting on 11/2/12.</p> <p>Temperature logs have been maintained since 11/3/12 and verify the temperature has remained at or above 160 degrees Fahrenheit.</p>	11/03/2012			

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	for the Hydrocollator water temperature was recorded 150 degrees F 19 of 19 days. The Chattanooga Hydrocollator was located in Rehabilitation Services at Forest Park off-site facility. Therefore, the water temperature did was not maintained the recommended temperature range of 160 and 166 degrees Fahrenheit.		Daily logs will continue to be maintained. Quality rounds will continue to include monitoring the temperature of the Hydrocollator Heating Units. Manager of Inpatient Therapy Services is responsible.		

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the Zoll E-series Defibrillator that were used on the ambulances had documented evidence of operator's Shift Checklist Procedure were conducted prior beginning of every shift.</p> <p>Findings included:</p> <p>1. The Zoll E-Series operator's manual chapter 1 Maintenance Tests states, "Because the E Series units must be maintained ready for immediate use, it is important for users to conduct the Operator's Shift Checklist procedure at the beginning of every shift."</p>	S1168	<p>All EMS staff was instructed by 10/26/12, on the correct procedure for performing the check of the monitor defibrillators. The procedure was updated to require the defibrillators be checked every shift and documented appropriately. A defibrillator check sheet was developed and educated to all EMS staff.</p> <p>Defibrillator check sheet will be monitored for completion and reported quarterly to the Patient Safety & Quality Committee.</p> <p>Quality Rounds will include the ambulances and verification that defibrillator checks are being completed and documented.</p>	10/28/2012	

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	<p>2. At 2:30 PM on 10/16/2012, staff member #5 indicated the EMS staff who operates the ambulances were not recording daily inspections of their defibrillators. The ambulance utilize Zoll E-Series and the the Zoll E-Series are not being used in any other area of the hospital.</p> <p>3. At 1:00 PM on 10/17/2012, staff member #18 indicated his/her staff were not recording routine daily inspections of the defibrillators that were used on the ambulances.</p>		The Director of Emergency and Critical Services is responsible.		

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S1186	<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 conduct fire drills as defined in the hospital policies and procedures for the Education Center offsite facility.</p> <p>Findings included:</p> <p>1. Life Safety Management Plan Policy #LS-1-1001, last reviewed</p>	S1186	A fire drill at the Education Center was completed on 10/31/12. Next drill is scheduled for May 2013 to return to original planned frequency. Security staff was educated that all drills must be completed as scheduled and if the building is unoccupied, they must return for the required drill.	10/31/2012
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	<p>12/2010, states, "Fire Drills shall be conducted every 12 months from the date of the last fire drill in all free-standing buildings classified as business occupancy and in which patients are seen or treated."</p> <p>2. Fire Drill Evacuations were reviewed for the hospital and the offsite locations. The last documented Fire Drill Evacuation conducted for the Education Center was 5/26/11. Therefore, the facility could not provided a fire drill of the Education Center within 12 months of the previous fire drill that was conducted in May of 2011.</p> <p>3. At 2:45 PM on 10/16/2012, staff member #8 indicated the Security Department conducts all the fire drills for their offsite locations. The staff member indicated the fire drill for the Education Center was not done May of 2012 with the other off-sites because the Education Center was closed the day security showed up to conduct the fire drill.</p>		<p>Fire Drill logs will be monitored to verify compliance.</p> <p>The Director of Facility Services is responsible.</p>				

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