

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150045	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER DEKALB HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1316 E SEVENTH ST AUBURN, IN 46706
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A000000	<p>The visit was for a Federal hospital re-certification survey.</p> <p>Facility Number: 005041</p> <p>Survey Date: 5-20-13 to 5-22-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith, BS MLT (ASCP) Medical Surveyor 3</p> <p>QA: cloughlin 05/29/13</p>	A000000		

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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A000085	<p>482.12(e)(2) CONTRACTED SERVICES</p> <p>The hospital must maintain a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the hospital failed to maintain a list of all contracted services, including the scope and nature of services provided for 20 of 39 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Contracts (approved 3-12) indicated the following: " A current list of all contracted services will be maintained on the DH intranet ...a list will be made available annually to the Board of Directors for approval. "</p> <p>2. On 5-20-13 at 1530 hours, an approved list of 19 contracted services was received from staff A15. The list of services failed to indicate a service provider for air exchange testing, anesthesia machines, biohazardous waste, elevators, endoscopes, exhaust hood certification, 2 fire services, generators, medical gas, medical physics, pest control, 5 radiology service agreement providers, snow removal, sterilizers, and trash disposal.</p> <p>3. Review of facility documentation indicated the following: air exchange</p>	A000085	<p>1,2,3,4</p> <p>The current list of contracts has been updated to include:</p> <p>Air exchangetesting, anesthesia machines, biohazardous waste, elevators, endoscopes, exhausthood certification, 2 fire services, generators, medical gas, medical physics, pest control, 5 radiology service agreement providers, snow removal, sterilizers, and trash disposal.</p> <p>Senior Executives will be responsible for QA /PI monitoring and reporting through the quality processes (including the Governing Board) for all service contracts in their areas. A form has been developed to expedite uniform reporting. The CEO will be responsible for assuring compliance.</p>	06/18/2013	

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	<p>testing by CS1, anesthesia machine service by CS2, biohazardous waste disposal by CS3, elevators service by CS4, endoscopes repair by CS5, exhaust hood certification by CS6, fire services by CS7 and CS8, generator service by CS9, medical gas by CS10, medical physics by CS11, pest control by CS12, 5 radiology service agreements by CS13, snow removal by CS18, sterilizer service by CS19, and trash disposal by CS20.</p> <p>4. On 5-22-13 at 1005 hours, staff A5 confirmed that the list of contracted services failed to include the 20 indicated service providers.</p>			

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A000283	<p>482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to -] (ii) Identify opportunities for improvement and changes that will lead to improvement.</p> <p>(c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care.</p> <p>(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.</p> <p>Based on document review, and interview, the facility failed to ensure that EMS (emergency medical services) reported quality data related to Glucometer issues to the quality assurance committee and failed to create a program that would ensure improvement with issues addressed by gathered data.</p> <p>Findings: 1. at 1:05 PM on 5/21/13, review of the 2011 and 2012 "EMS AccuChek Annual Summary" indicated: a. 2011 had a range of 6.78% to 19.30% of errors in the section "% Patient I.D.</p>	A000283	1a,b; 2a,b,c,d,e,f Director of Emergency Medical Services and Laboratory Services revised the current quality plan and reporting for accu-check testing. Continued monitoring will be reported at quality meetings, including board quality. This will be monitored by the Director of Emergency Medical Services with oversight of the Director of Lab Services. The responsible person for assuring that we are compliant is the Director of Lab Services.	06/18/2013			

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	<p>Errors"</p> <p>b. 2012 had a range of 7.35% to 28.57% of errors in the section "% Patient I.D. Errors"</p> <p>2. interview with staff member #67, the point of care testing/lab staff member, at 11:45 AM on 5/22/13 indicated:</p> <p>a. the data on the annual summary (listed in #1 above) is accumulated from the "Glucometer QA/QC/Pt Record logs completed by EMS staff on a monthly basis</p> <p>b. the data gathered, as stated in 1. above, was out of the accepted error range as determined by the point of care testing staff</p> <p>c. a majority of the errors were mostly incomplete documentation by EMS staff and not actual patient errors</p> <p>d. the quarterly reports that go to the quality assurance committee only lists the "% Patient I.D. Errors" by nursing staff- -the EMS data is deleted prior to reporting</p> <p>e. it is unknown what the EMS director does with EMS data or what processes were put into place to try to reduce the missed documentation/errors noted for two years by EMS staff</p> <p>f. there is no known quarterly report to the quality assurance committee by the EMS director</p>						

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A000308	<p>482.21 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>Based on document review and interview, the governing body failed to ensure that contracted services were evaluated and reviewed through the Quality Assessment and Performance Improvement (QA) program for 20 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Quality Management Plan (approved 6-12) failed to indicate that contracted services at the facility would be evaluated through the QA program. Review of program documentation failed to indicate monitoring and periodic reporting for the following 20 service providers: air exchange testing, anesthesia equipment, biohazardous waste disposal, endoscope service, elevators, exhaust hood certification, fire extinguishers, fire alarm system service, generators, medical gas, medical 	A000308	1,2,3,4 The current list of contracts has been updated to include: Air exchange testing, anesthesia machines, biohazardous waste, elevators, endoscopes, exhaust hood certification, 2 fire services, generators, medical gas, medical physics, pest control, 5 radiology service agreement providers, snow removal, sterilizers, and trash disposal. Senior Executives will be responsible for QA /PI monitoring and reporting through the quality processes (including the Governing Board) for all service contracts in their areas. A form has been developed to expedite uniform reporting. The CEO will be responsible for assuring compliance.	06/18/2013			

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	<p>physicist service, pest control, 5 radiology service agreement providers, snow removal and a trash disposal service.</p> <p>3. During an interview on 5-22-13 at 1010 hours, staff A5 confirmed that the Quality Management Plan lacked a provision for evaluating all contracted services through the QA program.</p> <p>4. During an interview on 5-22-13 at 1100 hours, staff A2 confirmed that the 2013 Board Quality minutes lacked documentation indicating that the 20 service providers were currently being reviewed through the QAPI program.</p>			

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A000386	<p>482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.</p> <p>Based on policy and procedure review, observation, and staff interview, the nurse executive failed to ensure that nursing staff followed facility policies related to the expiration date of opened glucometer test strips.</p> <p>Findings: 1. at 12:00 PM on 5/20/13, review of the policy and procedure "Glucose Monitoring: Accu - Chek Inform Test Strip Coding", with a revised date of 9/25/12, indicated: a. under "Quality Control:", it reads: "...QC (quality control) material is stable for 3 months once opened...Reagent strips are stable for 30 days once opened. Upon opening a new bottle of QC material or reagent strips, document the date it was put into use, the expiration date (30 days from date opened for reagent strips,...or expiration date on the bottle, whichever is sooner), and your initials on the vial."</p>	A000386	1a;2a;3a,b,c;4a,b Glucose monitoring strips will be checked utilizing the manufacture's expiration date. Policies have been changed to reflect the changes. Open containers will be dated and initialed when opened. The Director of Lab Services will monitor compliance.	05/24/2013			

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	<p>2. at 12:00 PM on 5/20/13, review of the policy and procedure "Glucose Monitoring: Accu - Chek Inform Blood Glucose Test", with a revised date of 9/25/12, indicated:</p> <p>a. under "Quality Control:", it reads: Upon opening a new bottle of Q.C. material or reagent strips, document the date it was put into use, the expiration date (30 days from date opened for reagent strips..."</p> <p>3. While on tour of the nursing units with staff member #51, the chief nursing officer, it was observed that:</p> <p>a. in the ED (emergency department) on 5/20/13 at 2:30 PM, the glucometer test strips were not dated when opened, dated with a 30 day expiration date, nor initialed when opened</p> <p>b. in the PACU (post anesthesia care unit--recovery room) unit on 5/21/13 at 10:20 AM, the glucometer test strips were not dated when opened, dated with a 30 day expiration date, nor initialed when opened</p> <p>c. in the ICU (intensive care unit) at 2:30 PM on 5/20/13, the glucometer test strips were not dated when opened, dated with a 30 day expiration date, nor initialed when opened</p> <p>4. interview with staff member #61, the infection control practitioner, at 9:40 AM</p>				

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	<p>on 5/22/13 indicated:</p> <ul style="list-style-type: none"> a. nursing is not following the current policy of dating the test strips when opening the vial with a 30 day expiration date b. two other policies, "Glucose Monitoring: Accu-Chek Inform Quality Control Test" and "AccuChek Inform Monthly Review" also indicate the test strips are only good for 30 days after opening with the bottles to be dated by nursing staff and initialed when opened 			
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A000749	<p>482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES</p> <p>The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.</p> <p>Based on policy and procedure review, document review, observation, and interview, the infection control committee failed to ensure that an active and effective hospital-wide infection control program was approved and implemented, as per policy and procedure, for 2013; failed to approve the housekeeping chemicals used through out the facility; and failed to monitor off site contracted cleaning personnel, including the approval of their housekeeping chemicals.</p> <p>Findings:</p> <p>1. at 12:15 PM on 5/22/13, review of the policy and procedure "Infection Prevention & Control Program Statement", with an effective date of 2/12 (no policy number), indicated:</p> <p>a. under "Policy" on page one, it reads: "...Elements of the Infection Prevention and Control Program include: Identifying risks in the healthcare organization through a risk assessment annually..."</p> <p>b. under "Policy", continued on page 9, it reads: "...Infection Prevention and Control Program evaluation and revision</p>	A000749	<p>1a,b; 2, 3a,b,c; The Infection Prevention & Control Program Statement policy will be reviewed for approval on 6/20/2013 at the Infection Control Committee Meeting. The annual risk assessment has been completed on 6/10/13 and will be submitted with the Infection Prevention and Control Program Statement policy at the 6/20/2013 Infection Control Committee Meeting. Annual review will be placed on the annual agenda to assure compliance and will be monitored by the Director of Infection Control.</p> <p>4a,b,c, 5; 6; 7a,b; 8, 9a,b,c,d</p> <p>The chemicals policy has been revised and will be submitted for approval to the infection Control Committee on 6/20/2013.</p> <p>All floors in patient care areas will be disinfected using an approved EPA registered disinfectant. This disinfectant will be approved by the Infection Control Committee on 6/20/2013.</p> <p>9e,f</p> <p>The policies and procedures and chemicals utilized for off-site cleaning will be approved by the</p>	06/20/2013	

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	<p>of the program annually..."</p> <p>2. review of the 2013 infection control committee meeting minutes of 2/21/13 and 5/16/13, at 9:20 AM on 5/20/13, indicated there was no action taken to approve an Infection Control Program for 2013</p> <p>3. interview with staff member #61, the infection control practitioner, at 9:40 AM on 5/22/13 indicated:</p> <p>a. the 2012 policy titled "infection control prevention and control program statement" indicates that an annual risk assessment will be completed and the plan/program will be updated/revised as needed</p> <p>b. a 2013 risk assessment has not been completed</p> <p>c. the infection control committee has not approved of a 2013 program plan for infection control and prevention</p> <p>4. at 9:00 AM on 5/22/13, review of the policy "Chemicals", policy number 4003 HK (from the "Housekeeping Manual"), with a most recent approval date of 10/12/11, indicated:</p> <p>a. approval of the policy was by the housekeeping supervisor (VP ancillary services and safety officer),</p> <p>b. on page 2, a description of "GP Forward" indicated this was a "general</p>		Infection Control Committee on 6/20/2013. This will be monitored by manager of Environmental Services with oversight by Infection Control..				

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	<p>purpose alkaline cleaner"</p> <p>c. on page 2, a description of "Virex" indicated this was a pH neutral germicidal cleaner/disinfectant used to disinfect all surfaces..."</p> <p>5. review of the infection control committee meeting minutes of 5/17/12 through 5/16/13, at 9:20 AM on 5/20/13, indicated there was no action taken by the infection control committee for approval of the chemicals used in the facility, as listed in the "Chemicals" policy</p> <p>6. while on tour of the ED (emergency department) on 5/20/13 at 1:15 PM, in the company of staff members #51, the chief nursing officer, and #54, the ED nursing director, it was observed that the product GP Forward was in the housekeeping closet</p> <p>7. interview with staff member #58, the ED housekeeper, at 1:20 PM on 5/20/13, indicated: a. the GP Forward product is a cleaner, not a disinfectant and is used to clean the hospital floors b. the Virex product is used on "touch surfaces"</p> <p>8. interview with staff member #63, the environmental services director, at 10:00 AM on 5/22/13, indicated there is a</p>				

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	<p>contracted housekeeping agency utilized at the two off site lab facilities</p> <p>9. interview with staff member # 61, the infection control practitioner, at 9:40 AM on 5/22/13 indicated:</p> <ul style="list-style-type: none"> a. the infection control committee has not approved of the chemicals used by housekeeping staff b. this staff member disagrees with the housekeeping manager's decision to clean floors with the GP Forward product instead of the Virex disinfectant c. housekeeping has not approached the infection control committee with the decision to discontinue disinfection of floors by using the GP Forward product d. the current "Chemicals" policy indicates Virex will be used on all surfaces, which should include floor surfaces e. this staff member has not been involved in the instruction of contracted off site housekeeping staff or in surveillance of their competency f. the infection control committee has not approved of the chemicals used by the off site contracted housekeeping staff, or of their policies/procedures for appropriate cleaning processes 				

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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005041</p> <p>Survey Date: 5-20-13 to 5-22-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith, BS MLT (ASCP) Medical Surveyor 3</p> <p>QA: claughlin 05/29/13</p>	S000000			

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S000102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on personnel file review, document review, and interview, the facility failed to ensure that state rules and regulations were complied with in reference to IC 16-28-13 for 2 of 3 technician/aide files reviewed. (1 telemetry tech = staff member N5, and one nurse aide = staff member N7)</p> <p>Findings: 1. review of IC 16-28-13-4 indicated that: a. "Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or (2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility; shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 10-13-3 or another</p>	S000102	<p>1a; 2a,.b; 3a; 4a,b,c</p> <p>The Human Resources Department will ensure that the C.N.A. registry is checked within 3 business days of hire for all nursing support staff (regardless of whether they will be doing patient care). The results of the C. N. A. registry search will be screen printed, dated, signed and placed in the employee's personnel file. This will be monitored by the V.P. of Human Resources and reported quarterly as a performance indicator.</p>	05/23/2013	

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	<p>source by law."</p> <p>2. at 10:50 AM on 5/22/13, review of personnel files indicated:</p> <p>a. staff member N5 was a telemetry tech hired on 11/26/12 who lacked documentation in the personnel file related to a nurse aide registry check being performed as part of the hiring process</p> <p>b. staff member N7 was a nurse aide hired 7/21/12 who lacked documentation in the personnel file related to a nurse aide registry check being performed as part of the hiring process</p> <p>3. review of the job description titled "Monitor Technician" at 11:30 AM on 5/22/13 indicated:</p> <p>a. under "Major Duties, But Not Limited To:", it reads: "Clinical:...6. Performs 12 Lead ECGs (electrocardiograms)...Assists nursing staff members with bathing, moving, and lifting patients. 11. Initiates and assists with basic life support as needed. 12. Performs Accuchecks for patients,...13. Starts IV's (intravenous), after completion of competency."</p> <p>4. interview with staff member # 65, human resources manager, at 11:30 AM on 5/22/13, indicated:</p> <p>a. it was unknown that the telemetry</p>						

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	<p>tech job description had nurse aide type duties listed</p> <p>b. it was thought that the nurse aide, N7, had a nurse aide registry check performed, but with no listing on the web site, no documentation of having performed the action was placed in the personnel file</p> <p>c. both staff member N5 and N7 personnel files should have had the nurse aide registry check done and are lacking this documentation in their files</p>			

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S000306	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(A)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(A) Ensuring the employment of personnel, in accordance with state and federal rules, whose qualifications are commensurate with anticipated job responsibilities.</p> <p>Based on policy and procedure review, and interview, the governing board failed to ensure that the medical staff reviewed/approved of the restraint policy annually as per the policy.</p> <p>Findings:</p> <p>1. at 8:30 AM on 5/21/13, review of the policy titled "Restraints" with a last "revised" date of 11/15/10, indicated:</p> <p>a. on page two under "Physician Training Requirements", it reads: "Physicians are required to review hospital restraint policies and procedures annually."</p> <p>b. the policy was signed by the chief nursing officer and the "physician advisor, medical services" on 11/15/10</p> <p>2. interview with staff member #51, the</p>	S000306	1a,b; 2a,b The Restraint Policy review date has been changed to annual in order to assure physician training and medical review of restraint policy and process. This will be placed as a permanent annual agenda item. This initiative will be monitored by the Executive Assistant of Clinical Services. This has been completed for the year, 2013.	05/31/2013			

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	<p>chief nursing officer, and staff member #52, the assistant chief nursing officer, at 11:10 AM on 5/21/13, indicated:</p> <p>a. there is no documentation in medical staff meeting minutes that would indicate that physicians reviewed the restraint policy since the authentication by the physician advisor of medical services of the policy on 11/15/10</p> <p>b. it cannot be determined that the policy has been implemented as written as there is no documentation of an annual review by the medical staff since November of 2010</p>				

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S000394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 20 of 39 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Contracts (approved 3-12) indicated the following: " A current list of all contracted services will be maintained on the DH intranet ...a list will be made available annually to the Board of Directors for approval. "</p> <p>2. On 5-20-13 at 1530 hours, an approved list of 19 contracted services was received from staff A15. The list of services failed to indicate a service provider for air exchange testing, anesthesia machines, biohazardous waste, elevators, endoscopes, exhaust hood certification, 2 fire services, generators,</p>	S000394	<p>1,2,3,4</p> <p>The current list of contracts has been updated to include:</p> <p>Air exchange testing, anesthesia machines, biohazardous waste, elevators, endoscopes, exhaust hood certification, 2 fire services, generators, medical gas, medical physics, pest control, 5 radiology service agreement providers, snow removal, sterilizers, and trash disposal.</p> <p>Senior Executives will be responsible for QA /PI monitoring and reporting through the quality processes (including the Governing Board). for all service contracts in their areas. A form has been developed to expedite uniform reporting. The CEO will be responsible for assuring compliance.</p>	06/18/2013			

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	<p>medical gas, medical physics, pest control, 5 radiology service agreement providers, snow removal, sterilizers, and trash disposal.</p> <p>3. Review of facility documentation indicated the following: air exchange testing by CS1, anesthesia machine service by CS2, biohazardous waste disposal by CS3, elevators service by CS4, endoscopes repair by CS5, exhaust hood certification by CS6, fire services by CS7 and CS8, generator service by CS9, medical gas by CS10, medical physics by CS11, pest control by CS12, 5 radiology service agreements by CS13, snow removal by CS18, sterilizer service by CS19, and trash disposal by CS20.</p> <p>4. On 5-22-13 at 1005 hours, staff A5 confirmed that the list of contracted services failed to include the 20 indicated service providers.</p>			

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to ensure that EMS (emergency medical services) reported quality data related to Glucometer issues to the quality assurance committee and the Quality Management Plan failed to ensure that contracted services were included in the Quality Assessment and Performance Improvement (QA) program for 20 contracted services.</p> <p>Findings: 1. at 1:05 PM on 5/21/13, review of the 2011 and 2012 "EMS AccuChek Annual Summary" indicated: a. 2011 had a range of 6.78% to 19.30% of errors in the section "% Patient I.D. Errors" b. 2012 had a range of 7.35% to 28.57% of errors in the section "% Patient I.D. Errors" 2. interview with staff member #67, the point of care testing/lab staff member, at 11:45 AM on</p>	S000406	<p>1a,b; 2a,b,c,d,e</p> <p>Director of Emergency Medical Services and Laboratory Services revised the current quality reporting for accu-check testing and the plan and continued monitoring will be reported to quality meetings, including Board Quality. This will be monitored by the Director of Emergency Medical Services with oversight of the Director of Lab Services.</p> <p>3, 4, 5, 6</p> <p>The current list of contracts has been updated to include: Air exchange testing, anesthesia machines, biohazardous waste, elevators, endoscopes, exhaust hood certification, 2 fire services,</p>	06/18/2013			

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	<p>5/22/13 indicated:</p> <ul style="list-style-type: none"> a. the data on the annual summary (listed in #1 above) is accumulated from the "Glucometer QA/QC/Pt Record logs completed by EMS staff on a monthly basis b. most of the errors are mostly incomplete documentation by EMS staff and not actual patient errors c. the quarterly reports that go to the quality assurance committee only lists the "% Patient I.D. Errors" by nursing staff--the EMS data is deleted prior to reporting d. it is unknown what the EMS director does with EMS data or what processes were put into place to try to reduce the missed documentation/errors noted for two years by EMS staff e. there is no known quarterly report to the quality assurance committee by the EMS director <p>3. The policy/procedure Quality Management Plan (approved 6-12) failed to indicate that contracted services were evaluated and reviewed through the QA program.</p> <p>4. Review of program documentation failed to indicate monitoring and periodic reporting for the following 20 service providers: air exchange testing, anesthesia equipment, biohazardous waste disposal, endoscope service, elevators, exhaust hood certification, fire extinguishers, fire alarm system service, generators, medical gas, medical physicist service, pest control, 5 radiology service agreement providers, snow removal and a trash disposal</p>		<p>generators, medical gas, medical physics, pest control, 5 radiology service agreement providers, snow removal, sterilizers, EMS, and trash disposal.</p> <p>Senior Executives will be responsible for QA /PI monitoring and reporting through the quality processes (including the Governing Board) for all service contracts in their areas. A form has been developed to expedite uniform reporting. The CEO will be responsible for assuring compliance.</p>		

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	<p>service.</p> <p>5. During an interview on 5-22-13 at 1010 hours, staff A5 confirmed that the Quality Management Plan lacked a provision for evaluating all contracted services through the QA program.</p> <p>6. During an interview on 5-22-13 at 1100 hours, staff A2 confirmed that the 2013 Board Quality minutes lacked documentation indicating that the 20 service providers were currently being reviewed through the QAPI program.</p>				

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S000556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on policy and procedure review, document review, and interview, the infection control committee failed to ensure that an active and effective hospital-wide infection control program was approved and implemented, as per policy and procedure, for 2013.</p> <p>Findings:</p> <p>1. at 12:15 PM on 5/22/13, review of the policy and procedure "Infection Prevention & Control Program Statement", with an effective date of 2/12 (no policy number), indicated:</p> <p>a. under "Policy" on page one, it reads: "...Elements of the Infection Prevention and Control Program include: Identifying risks in the healthcare organization through a risk assessment annually..."</p> <p>b. under "Policy", continued on page 9, it reads: "...Infection Prevention and Control Program evaluation and revision of the program annually..."</p>	S000556	<p>1a,b; 2, 3a,b,c</p> <p>The Infection Prevention & Control Program Statement policy will be reviewed for approval on 6/20/2013 at the Infection Control Committee Meeting.</p> <p>The annual risk assessment has been completed on 6/10/13 and will be submitted with the Infection Prevention and Control Program Statement policy at the 6/20/2013 Infection Control Committee Meeting. Annual review will be placed on the annual agenda to assure compliance and will be monitored by the Director of Infection Control.</p>	06/20/2013	

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	<p>2. review of the 2013 infection control committee meeting minutes of 2/21/13 and 5/16/13, at 9:20 AM on 5/20/13, indicated there was no action taken to approve an Infection Control Program for 2013</p> <p>3. interview with staff member #61, the infection control practitioner, at 9:40 AM on 5/22/13 indicated:</p> <p>a. the 2012 policy titled "infection control prevention and control program statement" indicates that an annual risk assessment will be completed and the plan/program will be updated/revised as needed</p> <p>b. a 2013 risk assessment has not been completed</p> <p>c. the infection control committee has not approved of a 2013 program plan for infection control and prevention</p>				

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S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on policy and procedure review, document review, observation, and interview, the infection control committee failed to approve the housekeeping chemicals used through out the facility and failed to monitor off site contracted cleaning personnel, including the approval of their housekeeping chemicals.</p> <p>Findings: 1. at 9:00 AM on 5/22/13, review of the policy "Chemicals", policy number 4003 HK (from the "Housekeeping Manual"), with a most recent approval date of 10/12/11, indicated: a. approval of the policy was by the housekeeping supervisor (VP ancillary services and safety officer), b. on page 2, a description of "GP</p>	S000592	1a,b,c; 2;3;4a,b;5,6a,b,c,d6e,f The chemicals policy has been revised and will be submitted for approval to the Infection Control Committee on 6/20/2013. All floors in patient care areas will be disinfected using an approved EPA registered disinfectant. This disinfectant will be approved by the Infection Control Committee on 6/20/2013. The policies and procedures and chemicals utilized for off-site cleaning will be approved by the Infection Control Committee on 6/20/2013. This will be the responsibility of the Infection Control Preventionist to maintain compliance.	06/20/2013

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	<p>Forward" indicated this was a "general purpose alkaline cleaner"</p> <p>c. on page 2, a description of "Virex" indicated this was a pH neutral germicidal cleaner/disinfectant used to disinfect all surfaces..."</p> <p>2. review of the infection control committee meeting minutes of 5/17/12 through 5/16/13, at 9:20 AM on 5/20/13, indicated there was no action taken by the infection control committee for approval of the chemicals used in the facility, as listed in the "Chemicals" policy</p> <p>3. while on tour of the ED (emergency department) on 5/20/13 at 1:15 PM, in the company of staff members #51, the chief nursing officer, and #54, the ED nursing director, it was observed that the product GP Forward was in the housekeeping closet</p> <p>4. interview with staff member #58, the ED housekeeper, at 1:20 PM on 5/20/13, indicated:</p> <p>a. the GP Forward product is a cleaner, not a disinfectant and is used to clean the hospital floors</p> <p>b. the Virex product is used on "touch surfaces"</p> <p>5. interview with staff member #63, the environmental services director, at 10:00</p>				

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	<p>AM on 5/22/13, indicated there is a contracted housekeeping agency utilized at the two off site lab facilities</p> <p>6. interview with staff member # 61, the infection control practitioner, at 9:40 AM on 5/22/13 indicated:</p> <ul style="list-style-type: none"> a. the infection control committee has not approved of the chemicals used by housekeeping staff b. this staff member disagrees with the housekeeping manager's decision to clean floors with the GP Forward product instead of the Virex disinfectant c. housekeeping has not approached the infection control committee with the decision to discontinue disinfection of floors by using the GP Forward product d. the current "Chemicals" policy indicates Virex will be used on all surfaces, which should include floor surfaces e. this staff member has not been involved in the instruction of contracted off site housekeeping staff or in surveillance of their competency f. the infection control committee has not approved of the chemicals used by the off site contracted housekeeping staff, or of their policies/procedures for appropriate cleaning processes 						

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, observation, and staff interview, the nurse executive failed to ensure that nursing staff followed facility policies related to the expiration date of opened glucometer</p>	S000912	1a;2a;3a,b,c;4a,b Glucose monitoring strips will be checked utilizing the manufacture's expiration date. Policies have been changed to reflect the changes. Open containers will be	05/24/2013

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	<p>test strips.</p> <p>Findings:</p> <p>1. at 12:00 PM on 5/20/13, review of the policy and procedure "Glucose Monitoring: Accu - Chek Inform Test Strip Coding", with a revised date of 9/25/12, indicated:</p> <p>a. under "Quality Control:", it reads: "...QC (quality control) material is stable for 3 months once opened...Reagent strips are stable for 30 days once opened. Upon opening a new bottle of QC material or reagent strips, document the date it was put into use, the expiration date (30 days from date opened for reagent strips,...or expiration date on the bottle, whichever is sooner), and your initials on the vial."</p> <p>2. at 12:00 PM on 5/20/13, review of the policy and procedure "Glucose Monitoring: Accu - Chek Inform Blood Glucose Test", with a revised date of 9/25/12, indicated:</p> <p>a. under "Quality Control:", it reads: Upon opening a new bottle of Q.C. material or reagent strips, document the date it was put into use, the expiration date (30 days from date opened for reagent strips..."</p> <p>3. While on tour of the nursing units with staff member #51, the chief nursing officer, it was observed that:</p>		<p>dated and initialed when opened. The Director of Lab Services will monitor compliance.</p>		

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	<p>a. in the ED (emergency department) on 5/20/13 at 2:30 PM, the glucometer test strips were not dated when opened, dated with a 30 day expiration date, nor initialed when opened</p> <p>b. in the PACU (post anesthesia care unit--recovery room) unit on 5/21/13 at 10:20 AM, the glucometer test strips were not dated when opened, dated with a 30 day expiration date, nor initialed when opened</p> <p>c. in the ICU (intensive care unit) at 2:30 PM on 5/20/13, the glucometer test strips were not dated when opened, dated with a 30 day expiration date, nor initialed when opened</p> <p>4. interview with staff member #61, the infection control practitioner, at 9:40 AM on 5/22/13 indicated:</p> <p>a. nursing is not following the current policy of dating the test strips when opening the vial with a 30 day expiration date</p> <p>b. two other policies, "Glucose Monitoring: Accu-Chek Inform Quality Control Test" and "AccuChek Inform Monthly Review" also indicate the test strips are only good for 30 days after opening with the bottles to be dated by nursing staff and initialed when opened</p>				

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the facility failed to ensure that no condition was created that might result in a hazard to patients or employees related to expired milk products in one refrigerator (obstetrics unit), dirty refrigerators in two nursing areas (intensive care unit and med/surg unit), dust under the plenum (lower shelf) of two blanket warmers (emergency department and intensive care unit) and an unsecured fire extinguisher in the cafeteria area.</p> <p>Findings:</p> <p>1. at 1:45 PM on 5/20/13, while on tour of the ED, emergency department, in the company of staff members #51, the chief nursing officer, and #54, the nursing manager of the ED, it was observed that the Enthermics blanket warmer had a layer of dust under the plenum of the unit</p> <p>2. interview with staff member #54, the ED nursing manager, at 1:45 PM on 5/20/13 indicated the blanket warmer was not on a routine cleaning</p>	S001118	<p>1; 2; 3a; 4; 9B All blanket warmers bottom pan which contains the electric heating elements were cleaned by the Maintenance Department on 5/20/2013. A line item for maintaining the cleanliness of this area was added to the tasks in the Equipment Management Plan. This will be monitored by the Director of Plant Operations and added to the quality plan. 3b; 5; 6a,b; 9a,b,A A new Policy was developed that states refrigerator's will be inspected and cleaned every week utilizing a cleaning log that identifies date and person. Cleaning of refrigerators have been communicated and added to an organization cleaning responsibility list. Dietary will be responsible for cleaning patient refrigerators. Director of Food Services will monitor. Unit staff will be responsible for cleaning</p>	06/20/2013	

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	<p>process</p> <p>3. while on tour of the ICU (intensive care unit) in the company of staff members #51, the chief nursing officer, and #54, the nursing manager of the ICU, at 2:40 PM on 5/20/13, it was observed that:</p> <ul style="list-style-type: none"> a. the Blickman blanket warmer had accumulated dust under the plenum and about the electrical components/coils of the equipment b. the patient food refrigerator was dirty with crumbs and food debris on the shelves of the main part of the refrigerator and on the bottom shelf of the freezer <p>4. interview with staff member #54, the ICU nurse manager, at 2:45 PM on 5/20/13 indicated the blanket warmer and refrigerator were not on a routine cleaning process or schedule</p> <p>5. at 1:45 PM on 5/21/13, while on tour of the medical/surgical nursing unit in the company of staff member #51, the chief nursing officer, and #62, the med/surg manager, it was observed that the patient food refrigerator was dirty with sticky shelves and crumbs and food debris under the vegetable drawers</p> <p>6. interview at 1:45 PM on 5/21/13 with staff member #62, the medical/surgical nursing unit manager, indicated:</p> <ul style="list-style-type: none"> a. nursing staff have initialed a monthly log in the "Day Shift" area for "Check refrigerator and microwave for spills" on 5/4/13 and 5/12/13, but may have only checked for out dates of supplies and not actually cleaned the refrigerator b. the log used, (with no title on the log, but with a Revised 03/2010 date on the bottom right of the page), does not specifically indicate that staff are to clean the refrigerator 		<p>staff refrigerators. Unit Directors will be responsible for monitoring. Pharmacy staff will be responsible for cleaning all refrigerators' containing medications. Director of Pharmancy will monitor. Implemented 6/20/2013. 10:11 The fire extinguisher in the cafeteria has been secured to the wall for safety. (5/21/13)</p>		

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	<p>7. at 2:30 PM on 5/21/13 while on tour of the OB (obstetrics) nursing unit in the company of staff member #51, the chief nursing officer, and #69, the OB manager, it was observed in the patient food refrigerator that two pints of milk had expired on 5/18/13 and one on 5/20/13</p> <p>8. at 2:30 PM on 5/21/13, interview with staff member #69, the OB manager, indicated dietary staff had been on the unit to stock supplies and remove expired products earlier that day (5/21/13) and had failed to remove the 3 cartons of milk that had expired</p> <p>9. interview with staff member #61, the infection control practitioner, at 9:40 AM on 5/22/13 indicated:</p> <p>a. there is currently no policy/procedure that requires the cleaning of refrigerators and/or blanket warmers</p> <p>b. a grid titled "Cleaning Responsibility Framework" is being developed that currently:</p> <p>A. only indicates that refrigerators will be cleaned "when visibly soiled" and does not indicate a specific time frame to assure routine cleaning occurs</p> <p>B. lacks the listing of blanket warmers for routine cleaning processes</p> <p>10. During tour of the main cafeteria on 5-21-13 between 10:00 AM and 11:00 AM, while accompanied by Staff Member #LS1, a fire extinguisher was observed, in the cafeteria serving line area, located on a ledge, next to a window. The fire extinguisher was not mounted on a wall or otherwise anchored for safety.</p> <p>11. In interview on 5-21-13 between 10:00 AM and 11:00 AM, Staff Member</p>			

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	#LS1 acknowledged the fire extinguisher was not mounted or otherwise anchored for safety.				

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S001164	<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. Based on observation and interview, the facility failed to perform preventive maintenance (PM) ensuring a safe working environment for employees in one department.</p> <p>Findings:</p> <p>1. During a tour on 5-21-13 at 1100 hours of building services chiller room, a Floor Maintainer 175 rpm floor buffer was observed without evidence of recent PM and a HP 175 rpm floor buffer was observed with a broken electrical grounding pin and without evidence of recent PM.</p> <p>2. During an interview on 5-21-13 at 1100 hours, staff A5 confirmed that the floor scrubbers lacked evidence of recent PM and had not been maintained.</p>	S001164	<p>1,2 The floor buffer's have been checked and repaired and have been added to the PM inspection list. The Director of Plant Operations will monitor.</p>	06/14/2013			

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S001168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the facility failed to ensure that defibrillator inspection and testing was performed as recommended by the manufacturer and ensure that the equipment was ready for use if needed.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 5-21-13 at 1250 hours, staff A5 and A9 were requested to provide a policy/procedure regarding Automatic External Defibrillator (AED) checks and none was provided prior to exit. The Zoll AED Plus Administrator 's Guide (2012) indicated the following: " Maintenance Checklist...when you periodically check your AED Plus ...verify electrodes are connected to the AED Plus and sealed in their package. Replace if expired. " During a tour on 5-21-13 at 1250 	S001168	<p>1; 2; 3; 4; 5 The Cardiopulmonary Rehabilitation Department developed a Policy and Procedure utilizing the manufacturer's guidelines and the defibrillator pads will be checked for expiration date. The Director of Cardiopulmonary Rehabilitation will be responsible for monitoring.</p>	06/14/2013	

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	<p>hours, the following condition was observed in the Cardiopulmonary Rehabilitation department: A Zoll AED Plus with expired defibrillator pads [CPR-D padz lot 3107 expired 8-04-2012] on top of the crash cart cabinet.</p> <p>4. During an interview on 5-21-13 at 1255 hours, rehab department staff A18 confirmed that the AED defibrillator pads expired in August, 2012.</p> <p>5. During an interview on 5-22-13 at 1000 hours, staff A4 confirmed that no policy/procedure for AED checks was available.</p>						