

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/07/2011
NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN47130		
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005009</p> <p>Dates: 12-05-11 through 12-07-11</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratory Surveyor</p> <p>QA: claughlin 12/13/11</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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S0556	<p>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 document review and staff interview, the facility failed to have an effective infection control program related to communicable disease immunizations/testing for 41 of 42 staff members.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff members #N6, P1, P2, P3, P4, P7, P9, P10, 1, 2, 3, 6-15, 19 and 20 personnel files lacked evidence of immunity to Varicella. Staff members #P1-P11, N1, N3-N11 and #1-20 personnel files lacked documentation of the time their PPDs were read. It could not be determined if the PPDs were read within 48 or 72 hours per guidelines. Facility PPD testing form states "Results <u>MUST</u> be read in 48-72 hours....." 	S0556	<p>I. PPD's Plan of correction a. The PPD tracking form will be updated to include the specific time of day the test was administered as well as the specific time of day the test was read. The form will also include the verbiage "Test must be read between 48-72 hours after being administered". This form will be updated and in use by January 15, 2012. b. During 2012, as each team member (based upon month of hire) comes due for their annual PPD test, this new form will be used. Full implementation will be completed by December 31, 2012 for existing team members. For any new team member, testing will be documented using this new form starting January 15, 2012. This plan follows CDC guidelines to stagger team member PPDs throughout the year. II. Varicella Plan of correction a. CMH started completing a Varicella Titer for all new hires in 2005. At that time, a titer was not completed on anyone who was already employed. An audit is</p>	01/06/2012			

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S0606	<p>4. Staff member #B5 verified the above at 10:15 a.m. on 12/7/11.</p> <p>410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review and staff</p>	S0606	<p>currently underway to identify any team member who did not have a varicella titer completed on them. Once identified, a titer will be performed. b. Due to the anticipated volume of team members and the logistics of communicating this requirement, getting the test performed, and following up with team members once the results are obtained, the completion date for this item is set for March 31 st . It is anticipated that 50% compliance will be reached by January 31 st , with 90% compliance reached by February 28 th , and full compliance reached by March 31 st . The Director of Human Resources is responsible for this plan.</p> <p>I. Hepatitis B Plan of correction a. An audit is currently underway</p>	01/06/2012	

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	<p>interview, the facility failed to document complete immunization histories for seven of twenty employees.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Three staff member personnel files (#'s 1, 2, & 8) lacked documentation of immunization history for hepatitis B, including whether this had been offered and whether or not this immunization had or had not been accepted. Two staff member personnel files (#'s 1, & 2,) and seven staff member personnel files (#'s 1,2,8,11,13, 19, & 20) lacked documentation of immunization histories for Rubella and Rubeola respectively. In interview on 12/06/11 at 11:30 a.m., staff member # 8 acknowledged the above missing documentation. 		<p>to determine which team members do not have documentation of Hepatitis B immunization history or declination. b. Once the audit is complete, the impacted team members will either need to provide immunization history if completed, begin the Hep B immunization process, or complete a declination form. Due to the length of time involved with the Audit of health records, the audit will be complete by January 31, 2012 with full compliance being reached by February 28, 2012. II. MMR Plan of correction a. An audit is currently underway to determine which team members do not have documentation of MMR immunization history. b. Once the audit is complete, the impacted team members will either need to provide immunization history if completed or begin the MMR immunization process. Due to the length of time involved with the Audit of health records, the audit will be complete by January 31, 2012 with full compliance being reached by February 28, 2012. The Director of Human Resources is responsible for this plan.</p>		

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S0781	<p>410 IAC 15-1.5-4(i)(2)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(2) Time of arrival, means of arrival, time treatment is initiated, and time examined by physician, if applicable. Based on document review and staff interview, the facility failed to ensure emergency department (ED) physicians documented the time of patient examination for 4 of 7 ED medical records.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Patient #N10 had an ED visit on 11/23/11. His/her medical record lacked documentation of physician exam time. 2. Patient #N11 had an ED visit on 11/23/11. His/her medical record lacked documentation of physician exam time. 3. Patient #N14 had an ED visit on 10/10/11. His/her medical record lacked documentation of physician exam time. 4. Patient #N24 had an ED visit on 9/11/11. His/her medical record lacked documentation of physician exam time. 5. Staff member #9 verified the above 	S0781	<p>The Director of Emergency Services met with the physician medical director of the ED on Friday December 16 th to discuss documentation issues.</p> <p>The physician medical director will contact all ED physicians via e-mail to re-educate them on the requirement to place examination time on the patient chart. Each physician will be required to send a confirmation e-mail acknowledging the re-education.</p> <p>Further, a notice will be placed in the physician's lounge, and a notice outlining the requirement will also be placed at each physician workstation.</p> <p>The above actions will be complete by January 2, 2012.</p> <p>ED Physician charts will be audited on a monthly basis by the ED leadership. Each month, 30 charts will be audited for patient examination time. Non-complaint charts will be addressed by the physician medical director with the specific physician for remediation.</p>	01/02/2012

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S0930	<p>information beginning at 11:30 a.m. on 12/7/11.</p> <p>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 document review and staff interview, the behavioral health unit (BHU) failed to assess patients for falls per policy for 3 of 3 BHU patients.</p> <p>Findings include:</p> <p>1. Review of patients #N7, N8, and N9 medical records indicated the following: (A) All three (3) patients were assessed as high risk for falls upon admission. (B) The medical records lacked evidence of further fall risk assessments.</p>	S0930	<p>The results of the monitoring will be forwarded to the Director of Quality for the hospital for review and recommendation.</p> <p>The above actions will begin in January, and will continue monthly. Results will be forwarded to Quality by the close of business the last day of each month.</p> <p>Responsible party: ED Physician Medical Director</p> <p>The Behavioral Health unit will adopt the Falls Assessment every shift that is currently used in the remainder of the hospital. This Falls Assessment has been sent to the printer and will be in place for use by January 13 th . A quality check for this item has been added to the monthly chart review conducted on the unit. Each full-time nurse will review 2 charts per month, the results will be forwarded to the Director of Quality for review and recommendation. The Director of Behavioral Health is responsible for this plan.</p>	01/06/2012	

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S1118	<p>2. Facility policy titled "Falls Precautions" last reviewed/revised 3/09 states on page 1: "10. Reassess fall risk per shift."</p> <p>3. Staff member #N20 verified the above at 11:20 on 12/6/11.</p> <p>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 created a condition that resulted in a hazard to the public and facility staff.</p> <p>Findings include:</p> <p>1. While touring the facility on 12-6-11 at 0955 hours with B#5, 2 fire extinguishers were observed unsecured on the floor inside the door of the facility power house creating a hazard for the public and facility staff.</p> <p>2. Interview with B#5 on 12-6-11 at 0955 hours confirmed 2 unsecured fire extinguishers were on the floor inside the</p>	S1118	<p>1) The fire extinguishers observed were immediately secured by maintenance staff.</p> <p>2) There were no patients or staff that were harmed by this observation</p> <p>3) The policy and procedures for fire extinguishers inspections was reviewed and modified to include verifying that all extinguishers at time of inspection are properly secured according to Life Safety Codes. An educational in-service has been scheduled for all maintenance staff members on this policy revision and procedural change, by the Director of Engineering Services, completion</p>	12/21/2011

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S1186	<p>door of the power house creating a hazard for the public and facility staff.</p> <p>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 document review and interview, the facility failed to follow the facility fire safety plan for 2 of 4 quarters in 2011.</p>	S1186	<p>date of 12/21/2011</p> <p>4) Monitoring of fire extinguishers will be performed by the department Compliance Coordinator for a period of three months; compliance findings will be reported to the Safety Committee, monitoring period Jan 2, 2012 thru March 31, 2012.</p> <p>The Director of Engineering Services is responsible for this plan.</p> <p>1) There were no patients or staff harmed by this observation 2) Environment of care policy on fire drills (policy F-003.0) has been modified to identify when</p>	12/21/2011	

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	<p>Findings include:</p> <ol style="list-style-type: none"> Review of facility fire drill documentation on 12-6-11 indicated the facility failed to conduct a fire drill during the 3rd quarter of 2011 on the night shift and during the month of July 2011, and during the 2nd quarter of 2011 on the day shift. Review of the facility document titled LIFE SAFETY MANAGEMENT PLAN on 12-6-11 indicated the following: Monthly fire drills are performed at various times and various areas of the healthcare facility (one drill per month per quarter). Interview with B#5 and B#9 on 12-6-11 at 1150 hours indicated fire drills are to be conducted monthly during each quarter to include each of the three shifts, nights, days, and evenings, in various areas of the healthcare facility; B#5 and B#9 confirmed drills were not conducted during the 3rd quarter of 2011 on the night shift or during the month of July 2011 on any shift and a drill was not conducted on the day shift during the 2nd quarter of 2011. 		<p>drills are to be conducted and who is responsible. Work orders will be assigned to Engineering Technicians with the shift and date of when each drill shall be completed. An in-service will be provided to Engineering Technicians by the Director of Engineering Services, in-service completion date of 12/21/2011.</p> <p>3) Monitoring of fire drills will be done by department Compliance Coordinator and reported to Environment of Care Committee to ensure compliance.</p> <p>The Director of Engineering Services is responsible for this plan.</p>		

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S1804	<p>410 IAC 15-1.6-5(a)</p> <p>(a) If the hospital provides psychiatric services, the service shall meet the needs of the patients served, within the scope of the service offered, in accordance with acceptable standards of practice.</p> <p>Based on document review, observation and staff interview, the facility failed to provide services on the behavioral health unit (BHU) according to standards of practice and policy for 2 of 3 patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Restraints" last reviewed/revised 3/09 states under definition: "A physical restraint is defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts a person's freedom of movement, physical activity or normal access to his or her body." 2. Review of patients #N7 or N8 medical records indicated the following: (A) The records lacked orders for a restraint. 3. During tour of the behavioral health unit (BHU) beginning at 11:00 a.m. on 12/6/11 the following was observed: 	S1804	Behavioral Health team members have been re-educated that roll belts are only to be used without the clasp. A form revision has been implemented to include this as a visual reminder. The form has a place to sign off to ensure that we have observed the patient demonstrating that they can remove the belt. The product research group is investigating products to see if a belt with Velcro is available for purchase. If for any reason a roll belt is used with the clasp closed and the patient cannot demonstrate ability to remove the belt, this will be treated as a restraint per policy. The Director of Behavioral Health is responsible for this plan.	12/09/2011	

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	<p>(A) Patients #N7 and N8 were seated in geri chairs with a belt secured around their waist that had a clasp type buckle on it. Upon request of staff, the patients were unable to unclasp the belt and remove the belt making the device a physical restraint.</p> <p>4. The application instruction sheet for the self-releasing roll belt states the following: (A) "DESCRIPTION OF PRODUCT: Self-releasing cotton belt with quick-release buckle. For bed application only." (B) "If the patient/resident is not able to easily self-release this product, it would be considered a restraint and therefore must be prescribed by a physician." (C) "Patients who cannot safely ambulate with out assistance, or those at risk for a fall or re-injury should not use this product.",</p> <p>5. Staff member #N20 indicated the following during tour of the unit: (A) Patients #N7 and N8 had belts that had a velcro closure and could be removed by the patients. (B) Patients #N7 and N8 did not have an order for a restraint. (C) He/she verified the presence of the clasp buckle on the belts and the fact that</p>				

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	the patients could not remove the belts after close observation of the belts.				