

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150026		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/08/2012	
NAME OF PROVIDER OR SUPPLIER  IU HEALTH GOSHEN HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 200 HIGH PARK AVE GOSHEN, IN 46526			
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 8/6/2012 through 8/8/2012</p> <p>Facility Number: 005025</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: clauglin 08/13/12</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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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</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>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on observation, facility documentation, manufacturer's literature, and interview, the governing board failed to ensure policies and procedures were in place to ensure patient safety with the use of heated supplies.</p> <p>Findings included:</p> <p>1. During the tour of the 4 West Med/Surg unit at 2:15 PM on 08/06/12, accompanied by staff members #4 and #5, a Steris Amsco warming cabinet containing blankets for patients was observed in the clean utility room. The digital display registered 165 degrees Fahrenheit (F). Staff member #5 indicated the unit staff didn't monitor the temperature of the unit.</p> <p>2. During the tour of the Obstetrical Unit</p>	S0322	<p>S 322 Amended: 10/23/2012 VP, Nursing and AVP, Surg Svcs will develop a new housewide policy &amp; procedure for warming cabinets, blanket warmers, and fluid warmers to address dating fluids in warming cabinets and temperature monitoring requirements. Nursing and Surg Svcs Colleagues will be in-serviced on the new policy &amp; procedure. <b>Responsible person: VP, Nursing Svcs</b> 09/24/12 10/31/12 11/09/12</p>	11/09/2012			

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	<p>at 3:00 PM on 08/06/12, accompanied by staff members #4 and #6, a Steris Amsco warming cabinet was observed in the clean supply room. The outside dial was set at 120 degrees for the top portion and the dial for the bottom portion was turned all the way to one end, but did not register a temperature. A thermometer inside the top portion registered 100 degrees F. and eight 1500 milliliter bottles of sterile water for irrigation were stored there. The bottom portion contained blankets, but did not contain a thermometer.</p> <p>The manufacturer's label on the bottles of solution indicated they were not to be warmed to a temperature greater than 50 degrees Celsius and should be discarded after 60 days of warming. Staff member #6 indicated the solution was used quickly and was not warmed for more than 60 days, but confirmed the staff did not date mark the bottles to ensure this time frame and did not monitor the temperatures of the cabinet.</p> <p>At 3:15 PM on 08/06/12, staff member #10 indicated the dial for the top portion was set at 120 degrees F., but confirmed the unit was not monitored and there was no temperature read-out for the bottom portion.</p> <p>3. During the tour of the Cardiovascular</p>						

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	<p>Lab at 9:50 AM on 08/07/12, accompanied by staff member #27, an Amsco warming cabinet, containing blankets for patients, was observed with the top portion registering 155 degrees F. and the bottom portion registering 152 degrees F. Staff member #27 indicated he/she was not aware of any temperature monitoring of the unit.</p> <p>4. During the tour of the Surgical Department beginning at 9:10 AM on 08/07/12, accompanied by staff members #28, #29, #30, and #38, a warming cabinet was observed in the substerile area. The top portion registered 101 degrees F. and the bottom portion registered 134 degrees F. Intravenous and irrigating fluids were dated and stored in the top portion and blankets were stored in the bottom portion. Documentation of temperature monitoring was provided.</p> <p>Another warmer containing only blankets was observed in the pre-operative area with temperature displays of 101 and 140 degrees F. At 10:15 AM on 08/07/12, staff member #31 indicated the maintenance department was responsible for the monitoring and an aide indicated they relied on the units alarming.</p> <p>At 10:20 AM on 08/07/12, staff member #32 indicated the Blickman warming</p>				

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	<p>cabinet in the recovery area was not monitored by staff.</p> <p>5. During the tour of the Intensive Care Unit at 10:20 AM on 08/07/12, accompanied by staff members #4, #7, and #33, a Blickman warming cabinet, containing blankets for patients, was observed registering 158 degrees F. Staff member #33 indicated the temperature of the cabinet was not monitored by staff.</p> <p>6. During the tour of the Emergency Department at 2:15 PM on 08/07/12, accompanied by staff members #7 and #41, a Blickman warming cabinet, containing blankets for patients, was observed registering 159 degrees F. Staff member #41 indicated the temperature of the cabinet was not monitored by staff.</p> <p>7. The manufacturer's manuals for the warmers were reviewed with staff member #3 who indicated he/she was not aware of any alarms on the units and only routine maintenance was performed by the facility's staff.</p> <p>The manual for the Amsco Warming Cabinet indicated, "...Burn Hazard: Do Not Use Liquids on or Inject In Living Tissue unless actual liquid temperature has been measured and is acceptable. Temperature of warming cabinet contents</p>						

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	<p>may be hotter than the displayed chamber air temperature. For patient safety, in accordance with good medical practice, always check liquid temperature prior to using." The document continued on page 2-2, " 2. Temperatures of solutions is the responsibility of the surgeon and is a matter of individual professional judgement and practice. In general, temperatures of solutions should not exceed 105 degrees F. and should always be checked prior to use. ...7. Blankets can generally be felt by hand by a qualified nurse for patient safe temperature."</p> <p>The manual for the Blickman Warming Cabinet indicated, "...Blickman does not recommend any operating temperature set point. For appropriate heating temperatures, please contact the manufacturer of the goods being heated."</p> <p>8. At 2:00 PM on 08/08/12, staff member #7 indicated the facility did not have a policy on dating fluids or on temperature monitoring of the warming cabinets.</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. Based on document review and staff interview, the facility failed to ensure the Dietary Department was part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>IU Health Goshen Hospital Quality Improvement Plan last reviewed January 2012, implements all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</li> <li>Review of the facility's QA&amp;I program indicated it did not include the Dietary Department.</li> <li>At 3:15 PM on 8/07/2012, staff</li> </ol>	S0406	<p><b>S 406 Amended: 10/23/2012</b> Director, Dietary Services to submit a Summary PI Performance Measures Report to Director, PI. Dietary Services Summary PI Performance Measures Report to be reviewed by the Performance Improvement &amp; Patient Safety Council. <b>Responsible person: Director, PI 10/22/12 11/01/12</b></p>	11/01/2012

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	member #1 indicated he/she could not located any QA documents that were forwarded to Performance Improvement and Patient Safety Council (PIPS). The staff member indicated that staff member #3 confirmed to him/she that the Dietary Department has not sent their quality studies to PIPS for evaluation and review.			

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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 observation, document review, and interview, the facility failed to follow manufacturer's directions for dating glucometer strips and control solutions to prevent outdated usage on 4 of the 5 nursing units toured (4 West, Obstetrical Unit, Pre-op area, and Emergency Department) and failed to ensure outdated supplies were discarded and replaced.</p> <p>Findings included:</p> <p>1. During the tour of the 4 West unit at 2:15 PM on 08/06/12, accompanied by staff members #4 and #5, the following observations were made:</p> <p>A. Glucometer supplies of SureStep Pro Test Strips and bottles of control solution, open, but not dated, with the glucose meter. The manufacturer's directions on the container of strips was to discard 4 months after opening and to discard the control solution 90 days after opening.</p> <p>B. In the Pediatric Crash Cart:</p> <p>1. Two of two 24 gauge Protectiv Plus Intravenous (IV) catheters, one expired</p>	S0554	<p>S 554 Amended: 10/23/2012 VP, Nursing will revise the Glucometer Policy &amp; Procedure to include noting the need to date Glucometer strips and control solutions when they are opened. VP, Nursing will add dating of Glucometer strips and control solutions to the Nursing Orientation Checklist and Annual Competency Checklist for glucometers. Nursing Svcs Colleagues will be in-serviced on the revised policy &amp; procedure.</p> <p><b>Responsible person: VP, Nursing Svcs VP</b>, Nursing had all outdated supplies on crash carts replaced. VP, Nursing will revise the Nursing Crash Cart Checks procedures to require that Nursing Staff will check Crash Carts for outdated supplies, and document that process, at the same time that Pharmacy is completing its monthly Crash Cart Checks. Nursing Svcs Colleagues will be in-serviced on the revised procedure. <b>Responsible person: VP, Nursing Svcs Director</b>, Imaging Svcs discarded the expired Cidex strips and obtained</p>	11/09/2012			

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	<p>02/06 and one expired 03/10.</p> <p>2. Two of two 20 gauge Protectiv Plus Intravenous (IV) catheters, one expired 12/09 and one expired 03/10.</p> <p>3. Two of two 22 gauge Protectiv Plus Intravenous (IV) catheters expired 02/10.</p> <p>4. Mini lab collection tubes, 4 of 4 green top expired 09/2011, 4 of 4 red top expired 07/2011, and 4 of 4 purple top expired 10/2011.</p> <p>5. One of two Foley catheters expired 05/2012.</p> <p>6. One of one 500 milliliter IV bag of 5% Dextrose/.225 Normal Saline expired Apr. 1, 2012.</p> <p>7. One of one 1000 milliliter IV bag of 0.9 Normal Saline expired Aug. 1, 2012.</p> <p>8. One of one 1000 milliliter IV bag of 5% Dextrose/.45 Normal Saline expired Jun. 1, 2012.</p> <p>9. One of one 1000 milliliter IV bag of 10% Dextrose expired Aug. 1, 2012.</p> <p>10. Two of two 50 milliliter IV bags of 0.9 Normal Saline expired May 1, 2012.</p> <p>At 2:20 PM on 08/06/12, staff member #5 indicated the crash carts were opened and checked monthly and the pharmacy department checked the medications.</p> <p>2. During the tour of the Obstetrical Unit at 3:00 PM on 08/06/12, accompanied by staff members #4 and #6, the following observations were made:</p>		<p>new strips. New Cidex strips were dated. <b>Responsible person: Director, Imaging Manager,</b> Surg Svcs discarded the expired Cidex test strips and obtained new strips. Manager, Surg Svcs in-serviced applicable Surg Svcs Colleagues of the need to continuously check Cidex strips for expiration dates. <b>Responsible person: Asst VP, Surg Svcs</b> 09/28/12 10/30/12 10/31/12 11/09/12 08/08/12 08/31/12 09/30/12 08/10/12 08/10/12 08/08/12 08/10/12</p>				

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	<p>A. Glucometer supplies of SureStep Pro Test Strips and bottles of control solution, open, but not dated, with the glucose meter. The manufacturer's directions on the container of strips was to discard 4 months after opening and to discard the control solution 90 days after opening.</p> <p>B. Three of thirteen blue top lab tubes, 2 expired 02/2012 and 1 expired 07/2012, in the cabinet in the clean supply room.</p> <p>3. During the tour of the Imaging Department at 3:15 PM on 08/06/12, accompanied by staff members #3 and #13, two containers of Cidex test strips for the disinfecting solution were observed. The open, in-use container had a manufacturer's expiration date of 02/2010 as well as the back stock container of strips.</p> <p>4. During the tour of the Decontamination area at 9:40 AM on 08/07/12, accompanied by staff members #28, #29, and #30, a container of open Cidex test strips with an expiration date of 12/2010 was observed on the counter.</p> <p>5. During the tour of the Pre-op area at 10:15 AM on 08/07/12, accompanied by staff members #7 and #32, glucometer supplies of SureStep Pro Test Strips and bottles of control solution, open, but not</p>			

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	<p>dated, were observed with the glucose meter. Staff member #32 indicated staff just checked the manufacturer's expiration date on the containers. The manufacturer's directions on the container of strips was to discard 4 months after opening and to discard the control solution 90 days after opening.</p> <p>6. During the tour of the Emergency Department at 2:15 PM on 08/07/12, accompanied by staff members #7 and #41, glucometer supplies of SureStep Pro Test Strips and bottles of control solution, open, but not dated, were observed with the glucose meter in the triage room. The manufacturer's directions on the container of strips was to discard 4 months after opening and to discard the control solution 90 days after opening.</p> <p>7. Review of the manufacturer's manual for the SureStep Lexx glucometer system indicated, "...Discard any unused test strips 4 months after opening. Write the opened date on the bottle when you open it." The instructions continued regarding the bottles of control solution, "...Discard any unused portion 3 months after opening. Write the opened date on the vial when you open it."</p>				

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S0606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 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.</p> <p>Based on documentation and staff interview, the facility failed to ensure reliable documentation of Varicella vaccination for 21 of 23 staff member's health records reviewed (#A1, A2, A3, A4, A5, A6, A7, A9, A10, A12, A13, A14, A13, P3, P4, P5, P6, P7, P8, P9, and P10) and report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food for 7 of 7 Dietary staff reviewed (#A4, A9, A10, A12, A13, A14, and A15).</p>	S0606	<p>S 606 Amended: 10/23/2012 Director, Human Resources developed a recommendation regarding the need for Colleagues to provide documentation of Varicella vaccination and submitted the recommendation for consideration/approval by the IUHGH Infection Prevention Committee. Recommendation to be considered for approval by the IUHGH Infection Prevention Committee with a recommendation for approval to the IUHGH Medical Executive Committee. Recommendation to be considered for approval by the IUHGH Medical Executive Committee. Colleague Health</p>	10/09/2012			

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	<p>Findings included:</p> <p>1. Personal/Health records were reviewed for IU Health Goshen hospital employees and contracted staff. Twenty-one of twenty-three hospital employees health records identified the employees provided a questionnaire of child hood disease history or the health records did not have any documentation on Varicella vaccination history at all. Therefore, 21 of 23 hospital employees did not have reliable documentation of having a Varicella vaccination. The hospital employees are: #A1, A2, A3, A4, A5, A6, A7, A9, A10, A12, A13, A14, A13, P3, P4, P5, P6, P7, P8, P9, and P10.</p> <p>2. The Colleague Health Program last reviewed 8/29/2011 did not request reliable documentation on Varicella vaccination.</p> <p>3. At 11:05 AM on 8/8/2012, staff member #39 indicated Human</p>		<p>Nurse will monitor to ensure that documented proof of Varicella vaccination is provided as part of the New Hire Clearance processes. <b>Responsible person: VP, HR &amp; Compliance</b> Director, Food &amp; Nutrition provided Colleague Health with a copy of a "Food Employee Reporting Agreement" that includes information on how to report diseases and/or infections that are transmittable through food. Director, Human Resources mandated that Colleague Health will have these forms completed for all Food &amp; Nutrition new hires. Completed "Food Employee Reporting Agreements" will be maintained in the Colleagues' Colleague Health file. Colleague Health Nurse will monitor to ensure completion of the "Food Employee Reporting Agreement" as part of the New Hire Clearance processes. <b>Responsible person: Director, HR</b> 08/23/12 09/24/12 10/09/12 ongoing 08/21/12 08/21/12 ongoing ongoing</p>		

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	<p>Resources discovered about 4 years ago that all hospital staff must provide reliable documentation of Varicella vaccination or the hospital will provide the vaccination to the staff member.</p> <p>4. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), of the food employee or applicant: (1) is diagnosed with an illness due to:(A) Salmonella spp.; (B) Shigella spp.; (C) Shiga</p>			

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	<p>toxin-producing Escherichia Coli; (D) Hepatitis A virus; or (E) Norovirus "</p> <p>5. Seven of 7 Dietary staff employee training files and health records were reviewed: #A4, A9, A10, A12, A13, A14, and A15. The facility could not provide documentation that 7 of 7 Dietary Staff were provided information how to report diseases and/or infections that are transmittable through food to the hospital.</p> <p>6. At 1:10 PM on 8/8/2012, staff member #8 confirmed the Dietary Department was not complying with the requirements of 410 IAC 7-24-120.</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 physician orders were followed for 1 of 2 newborns (#N11) regarding vital signs after delivery.</p> <p>Findings included:</p> <p>1. Review of the medical record for infant #N11, delivered at 0933 on 02/24/12, indicated orders for vital signs every 30 minutes x 5, every 6 hours x3, then twice a day at 0500 and 1700. The record lacked documentation of any vital signs until 1140 on 02/24/12, then continued at 1210, 1214, 1830, and 2344.</p> <p>2. The facility policy "Newborn Stabilization", last revised 06/2011, indicated, "...Ongoing Care- Normal Care Newborn, 11. Assess initial vital signs (VS) within 15 minutes of birth then every 30 minutes x 2 hours, then if stable, every 6 hours x 3, then every shift."</p>	S0930	<p><b>S 930 Amended: 10/23/2012</b> Meditech Build Team to remedy where the OB-Traceview/Meditech interface "drops" some OB-Traceview data elements when mapping documentation elements from OB-Traceview into Meditech (EMR). Director, OB to in-service OB Colleagues to review the Newborn Stabilization Policy and vital signs expectations. <b>Responsible person: Director, OB Svcs 09/25/12 09/30/12</b></p>	09/30/2012	

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	3. At 2:00 PM on 08/08/12, staff member #7 and a staff member from the obstetrical unit confirmed the lack of documentation of the vital signs as ordered for infant #N11.			

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S0932	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on medical record review, policy and procedure review, and interview, the facility failed to ensure all patients had an individualized care plan completed according to policy for 4 of 14 inpatient closed records reviewed (#N4, N5, N13, and N14).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The medical record for patient #N4, admitted at 0810 on 04/09/12, indicated a care plan was not done until 04/11/12, 2 days later.</li> <li>The medical record for patient #N5, admitted at 1255 on 05/01/12 and discharged at 1444 on 05/02/12, lacked documentation of a care plan.</li> <li>The medical record for patient #N13, admitted at 0722 on 04/04/12 and discharged at 1356 on 04/06/12, lacked documentation of a care plan.</li> </ol>	S0932	<p>S 932 Amended: 10/23/2012 VP, Nursing Svcs to meet with another IU Health facility to review the other facility's modifications to the Meditech application to meet this requirement. VP, Nursing Svcs to revise the Nursing Assessment Policy &amp; Procedure to delineate how the Plan of Care is automated and driven by the patient's individual findings on assessment, when developing interventions, when developing goals, and in outcomes documentation. Nursing Svcs Colleagues will be in-serviced on the revised Nursing Assessment Policy &amp; Procedure and expectations regarding documentation regarding the patient's Plan of Care.</p> <p><b>Responsible person: VP, Nursing Svcs 10/31/12 11/30/12 12/31/12</b></p>	12/31/2012	

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	<p>4. The medical record for patient #N14, admitted at 1230 on 02/27/12, indicated a care plan was not done until 1725 on 02/28/12, over 24 hours later.</p> <p>5. The facility policy "Patient Care Planning", last revised 12/09, indicated, "1. Every patient admitted to the hospital will have an individualized Plan of Care. ...4. The nurse develops/documents a Plan of Care for each patient, determined by the patient's needs, goals, time frames, settings, and services required to meet the patient's needs or goals. The Plan of Care will include an outcome statement for each problem identified. 5. The registered nurse identifies expected outcomes/goals for a plan individualized to the patient or situation. 6. The registered nurse implements the Plan of Care for the patient in a safe manner within 24 hours of admission/arrival."</p> <p>6. At 11:30 AM on 08/07/12, staff member #20 indicated the electronic medical record system issued a reminder at 24 hours if a care plan was not done, but there was no set time frame for the care plan to be done prior to that. Staff member #7 indicated sometimes the staff waited until a definitive diagnosis was determined to create the care plan.</p> <p>7. At 2:15 PM on 08/08/12, staff</p>			

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	members #7 and #20 confirmed the medical record findings.			

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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 for 5 of 5 patients who received blood transfusions (#N1, N2, N3, N4, and N5).</p> <p>Findings included:</p> <p>1. The facility policy "Blood Products Administration", last revised 06/10, indicated, "...5. Using two licensed hospital personnel, repeat the verification process on the nursing unit. Then, at the bedside, verify that the patient name and medical record number on the ID band match those on the transfusion slip. Both licensed hospital personnel must complete the appropriate assessments in Meditech. ...After 30 minutes, unused unspiked blood would be returned for disposal. ...9. Obtain baseline vital signs (VS): T, P, R &amp; BP and respiratory status.</p>	S0952	<p>S 952 Amended: 10/23/2012 Unit Directors will provide in-services to Nursing Colleagues to remind them of the 30 minute rule for hanging blood after the blood is signed out of the Blood Bank. The VP, Nursing Svcs will add the 30 minute rule regarding blood to the Nursing Orientation Checklist and Annual Competency Checklist for Blood Transfusions. <b>Sample monitoring to be conducted to ensure compliance.</b> <b>Responsible person: VP, Nursing Svcs</b> 09/30/12 10/31/12 11/30/12</p>	11/30/2012			

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	<p>[Temperature, pulse, respirations, &amp; blood pressure] ...18. Use new blood tubing for each unit of blood. ...20. ...Check VS 15 minutes after infusion begins, again in 30 minutes and after each unit is totally infused."</p> <p>2. The medical record for patient #N1 indicated the following documentation for blood administration: A. Unit #38GC26152 released from the blood bank at 1459 on 01/25/12 B. Checks by 2 nurses on the unit at 1518 on 01/25/12 C. Start time of the unit of blood at 1455 on 01/25/12, 23 minutes before it was checked D. Fifteen minute VS checks at 1520 on 01/25/12, 25 minutes after the start time E. Post initiation check (30 minutes after 15 minute check or 45 minutes after start time) at 1550 on 01/25/12, 55 minutes after start time</p> <p>3. The medical record for patient #N2 indicated the following documentation for blood administration: A. Unit #38KV26219 released from the blood bank at 1023 on 02/08/12 B. Start time of 1100 on 02/08/12, 37 minutes after release from the blood bank C. Post initiation check (45 minutes from start time) at 1227 on 02/08/12, 1 hour and 27 minutes after the start time</p>						

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	<p>D. End time of 1345 on 02/08/12, but ending VS at 1359 on 02/08/12, which was 14 minutes after the start time of the second unit</p> <p>E. A second unit of blood #38GZ63133 was released from the blood bank at 1336 on 02/08/12</p> <p>F. Second unit started at 1345 on 02/08/12, the exact time that the first unit finished</p> <p>G. Fifteen minute VS at 1416 on 02/08/12, 31 minutes after the start time</p> <p>H. Post initiation check (45 minutes from start time) at 1453 on 02/08/12, 1 hour and 8 minutes after the start time</p> <p>4. The medical record for patient #N3 indicated the following documentation for blood administration:</p> <p>A. Unit #38E56206 released from the blood bank at 1338 on 03/14/12</p> <p>B. Completion time of 1630 on 03/14/12</p> <p>C. Completion VS at 1615 on 03/14/12, 15 minutes before completion of the blood</p> <p>5. The medical record for patient #N4 indicated the following documentation for blood administration:</p> <p>A. Unit #38GZ64977 released from the blood bank at 0919 on 04/09/12</p> <p>B. Start time of 1000 on 04/09/12, 41 minutes after release from blood bank</p>						

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	<p>6. The medical record for patient #N5 indicated the following documentation for blood administration:</p> <p>A. Unit #38FH92324 released from the blood bank at 1216 on 05/01/12</p> <p>B. Checks by 2 nurses on the unit at 1320 on 05/01/12</p> <p>C. Start time of the unit of blood at 1315 on 05/01/12, 5 minutes before it was checked and almost an hour after release from the blood bank</p> <p>D. Completion time of 1625 on 05/01/12</p> <p>E. A second unit of blood #38KX09194 was released from the blood bank at 1621 on 05/01/12</p> <p>F. Second unit started at 1625 on 05/01/12, the exact time that the first unit finished</p> <p>5. The medical records were reviewed electronically with staff members #7 and #20 between 1040 and 1315 on 08/07/12. Both staff members confirmed the medical record findings and although they thought some of the discrepancies could be due to the times appearing on the computer system, no other documentation was provided.</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 observation, documentation review, and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in four (4) instances: Main Housekeeping Store Room, Outside Generators, and the Laboratory.</p> <p>Findings included:</p> <p>1. IU Health Goshen Hospital Administrative Manual last reviewed February 2010 requires the hospital to comply with OSHA Safety Standard requirements.</p>	S1118	<p><b>S1118 Amended: 10/23/2012</b> Director, Plant Ops ordered two double 32 oz. bottle stations with eyewash solution for placement in the generator building as an <b>interim safety measure for Colleagues</b>. Director, Plant Ops is developing construction plans to install an eyewash station in the generator building and to integrate installation into an IUHGH construction schedule. Eyewash station to be installed in the generator building. Manager, Environmental Svcs ordered goggles, gloves, and aprons. Ordered equipment was received and was stored in the Environmental Svcs Shop. Manager, Environmental Svcs educated Environmental staff of the availability and location of newly received PPE. The eyewash station in Histology will be removed from the utility sink. Bottle stations with eyewash solution will be placed in</p>	12/21/2012	

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	<p>2. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>3. The June 2012 Monthly Generator Log notes the batteries are checked weekly for: charging rate; terminal clean and tight; add distilled water to maintain proper levels; Use goggles and gloves when checking batteries.</p>		<p><b>Histology as an interim safety measure for Colleagues.</b> Director, Plant Ops is developing construction plans to install an eyewash station in Histology and to integrate installation into an IUHGH construction schedule. Eyewash station to be installed in Histology. Director, Plan Ops will remove the eyewashing spray hoses from the "dirty" sinks in Urinalysis. Note: Another nearby sink (within a 10 seconds reach) has the required eyewash station. <b>Responsible person:</b> <b>VP, Hosp Ops</b> 08/23/12 09/30/12 10/31/12 11/30/12 12/21/12 08/08/12 08/10/12 08/14/12 09/30/12 09/30/12 09/30/12 10/31/12 11/30/12 12/21/12 09/07/12</p>		

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	<p>4. The two enclosed Diesel Generators located outside were observed with 4-12 volt batteries each. Each enclosed Generator was observed without an eye wash station for a possibility of acid splash into the eyes when the water levels are checked weekly.</p> <p>5. T3 Automatic Scrubber operating manual Charging Batteries states, "When servicing batteries, wear protective gloves and eye protection when handling batteries and battery cables. Avoid contact with battery acid."</p> <p>6. At 3:22 PM on 8/6/2012, staff member #15 indicated he/she needs to use goggles and an apron when checking the water level of the floor scrubber's batteries. The staff member confirmed the store room did not have the goggles and apron in the store room.</p> <p>7. At 1:10 PM on 8/8/2012, the laboratory was toured and two</p>						

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	<p>areas of the Laboratory (Urinalysis, Histology) were observed with dirty utility sinks and an eye washing spray connectors also attached for the dirty utility sinks. The Histology area also had a red container labeled "Hazardous Material" stored in one bay of the two bay utility sink.</p> <p>8. At 1:17 PM on 8/8/2012, staff member #42 indicated the two sinks that the eye washing spray hoses were connected to are "dirty" sinks used for urine, blood, and other containments. The staff member indicated the lab has two sinks that are designed for hand washing only and confirmed those sinks should be the only sinks the eye washing spray hoses should be attached to for safety concerns.</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 assure the M2 Hydrocollator routine preventive maintenance was performed according to the manufacturer's recommendations.</p> <p>Findings included:</p> <p>1. The M2 Chattanooga Hydrocollator Heating Unit operation manual states, "The recommended operating temperature is 160 F to 166 F. The temperature of the water should be checked with a thermometer after every adjustment, before using the</p>	S1162	<p>S1162 Amended: 10/23/2012 Director, Rehab Svcs corrected the temperature on the Hydrocollator. Director, Rehab Svcs modified the Hydrocollator Temperature Control Logs to indicate an acceptable level of 160-166 degrees F. Director, Rehab Svcs revised policies &amp; procedures related to Hydrocollator temperature monitoring to follow manufacturer's recommendations. Director, Rehab Svcs provided orientation to the revised policies &amp; procedures and revised Hydrocollator Temperature Control Logs to Rehab Svcs Colleagues. <b>Responsible person: Director, Rehab Svcs</b> 08/09/12 08/09/12 08/09/12 08/22/12</p>	08/22/2012			

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	HotPacs."  2. The month daily Hot Pack (Hydrocollator) Temperature Control Log was reviewed for July 2012. Ten of the 31 days in July the offsite Rehab facility was closed. The temperature log notes 8 out of 21 days the Hydrocollator were out of the manufacturer required temperature range. The temperature log was also in conflict with the manufacturer's recommended temperature range of 160 to 166. The log had an acceptable temperature range of 150 F to 170 F.				

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on documentation review and staff interview, the facility failed to ensure preventive maintenance documentation was completed according to policy and manufacturer for the 2 Specialty Patient Beds, Warming Cabinet, and 1 Air Handling Unit.</p> <p>Findings included:</p> <p>1. Environmental Maintenance policy last reviewed February 2010 states, "Preventive Maintenance System (PMS) - A computerized information system used to facilitate the scheduling, monitoring, and documentation of equipment and environmental</p>	S1164	<p><b>S1164 Amended: 10/23/2012</b> Director, Plant Ops reviewed requirements for fully completing PM Checklists with Plant Ops Colleagues. Manager, Plant Ops re-inspected the Blickman Warming Cabinet (Note: there is no Steris Warming Cabinet in our OB Department); affixed a Preventive Maintenance Tag; and, entered the PM service into the preventive maintenance computer system. Manager, Plant Ops completed an inspection of the second warming cabinet; affixed a Preventive Maintenance Tag; and, entered the PM service into the preventive maintenance computer system. <b>Responsible person: Director, Plant Ops</b> 08/17/12 08/13/12 08/13/12</p>	08/17/2012			

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	<p>maintenance. The engineer completes the scheduled maintenance work order, indicating specific preventive or corrective actions he has taken and noting the date the scheduled maintenance was completed, and submits the work order to the Plant Operations office for entry in the PMS."</p> <p>2. The Affinity Three Birthing Bed Physical Plant scheduled preventive maintenance work order #71829 was reviewed. The work order has a check list of items that needed to be inspected with an appropriate check box next to the item to indicate the work was completed by staff. However, the work order identified a completion date of 7/31/2012 signed by physical plant personnel. However, without any of the selected items checked to identified the assigned items on the scheduled work order were completed to assure proper operation of the equipment. This documentation was reviewed and confirmed by staff member #17 that</p>				

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	<p>the work order was not completed.</p> <p>3. The Versa Care Bed Physical Plant scheduled preventive maintenance work order #79145 was reviewed. The work order has a check list of items that needed to be inspected with an appropriate check box next to the item to indicate the work was completed by staff. However, the work order identified a completion date of 7/31/2012 signed by physical plant personnel. However, without any of the selected items checked to identified the assigned items on the scheduled work order were ever completed to assure proper operation of the equipment. This documentation was reviewed and confirmed by staff member #17 that the work order was not completed.</p> <p>4. The Air Handler Physical Plant scheduled preventive maintenance work order #78158 was reviewed. The work order has a check list of items that needed to be inspected with an appropriate check box next</p>						

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	<p>to the item to indicate the work was completed by staff. However, the work order identified a completion date of 6/26/2012 signed by physical plant personnel. However, without any of the selected items checked to identified the assigned items on the scheduled work order were ever completed to assure proper operation of the equipment. This documentation was reviewed and confirmed by staff member #3 that the work order was not completed.</p> <p>5. At 3:30 PM on 8/6/2012 The Steris Warming Cabinet located in the OB Department was inspected for preventive maintenance completion tag. The warming cabinet was observed without a Preventive Maintenance Completion Tag.</p> <p>6. At 3:00 PM on 8/7/2012, staff member #3 indicated the OB Department had two warming cabinets located in that location. The staff would have a work order</p>						

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	for one of the units and the staff would complete that work order. However, the staff would conduct preventive maintenance on the other warming cabinet without filling out a scheduled work order. Staff member #3 indicated without documentation on the second warming cabinet, the work cannot be assured it was ever done on the warming cabinet that was located in OB Department without a Preventive Maintenance Completion Tag.				

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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 observation, documentation review, and staff interview, the facility failed to ensure the Code Master Defibrillator/Monitor was checked on every shift as recommended by the manufacturer's operating manual.</p> <p>Findings included:</p> <p>1. At 3:27 PM on 8/6/2012, the Imaging Department was toured. The CT room was observed with a crash cart. The crash cart had a HP Code Master Defibrillator/Monitor on top of it. The cart also had a Crash Cart Checklist. The Crash Cart Checklist was performed daily. The daily check list included: Defib power,</p>	S1168	<p>S1168 Amended: 10/31/2012 Director, Imaging Svcs revised the Crash Cart Log to note checks are to be done at 0700 hrs and 2300 hrs. Director, Imaging Svcs counseled staff of the revised Crash Cart Log and revised checking requirement. <b>Responsible person: Director, Imaging 08/08/12 08/14/12</b></p>	08/14/2012			

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	<p>defib/pacer/EKG, supplies, seals intact, defib pacer test. The log August 2012 log identified the defibrillator was checked once each day.</p> <p>2. The HP Code Master Defibrillator/Monitor operating manual states, "These checks are intended to briefly verify the proper operation of the Code Master defibrillator/monitor. Regularly performed a test routine incorporating the following checks along with visual inspection of all cables, paddles, and controls. Perform the following checks every shift: Verify that the instrument is connected to AC power, and that the Battery Charge and AC Power lights are on; Check for adequate thermal paper in recorder; Check for ECG leads, electricodes, and adequate electrolyte paste and defibrillator electrodes; and If unit is used for shock advisory, check for electrodes and electrodes adapter cable."</p>				

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	3. At 3:35 PM on 8/6/2012, staff member #11 indicated the Imaging Department was open 24 hours and the defibrillator was only checked once a day. The staff member indicated the department operates on 3 shifts.			

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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 and staff interview, the facility failed to ensure the offsite's are conducting 1 quarterly fire drill per sif for (4) offsite locations: Sleep Center, Center for Rehab-Nappanee, Center for Rehab-Middlebury, and Center for Rehab-Goshen.</p> <p>Findings included:</p>	S1186	<p>S1186 Amended: 10/23/2012 Director, Plant Ops has scheduled 3 rd Qtr 2012 fire drills at the Sleep Center, Goshen Rehab Facility, Middlebury Rehab Facility, and, Nappanee Rehab Facility. 3 rd Qtr 2012 fire drills were completed: 1. Nappanee Rehab Facility 2. Goshen Rehab Facility 3. Sleep Center 4. Middlebury Rehab Facility <b>Responsible person: Director, Plant Ops</b> 08/13/12 09/04/12 09/05/12 09/11/12 09/12/12</p>	09/12/2012			

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	<p>1. Management Plan for Safety last reviewed 3/2012 article III states, "To establish a Life Safety Management Program designed to protect patients, visitors, colleagues, and property from fire and smoke. This is accomplished by training as well as identifying and maintaining all applicable required structural features of fire protection to LSC (Life Safety Code) standards."</p> <p>2. Life Safety Code NFPA 101 2000 edition requires Fire Drills to be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance, engineers, and administrative staff).</p> <p>3. The 4 hospital offsite health care facilities fire drills were reviewed. Each offsite facility only conducted 1 fire drill in 2011 and 1 fire drill in 2010. The facility operates only 1 shift. Therefore, the 4 offsite health care facilities missed 3 required quarterly drills for 2010</p>			

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	and 2011.  4. At 2:30 PM on 8/6/2012, staff member #3 indicated the 4 offsite's do take care of outpatients in the 4 offsites. The staff member confirmed that LSC requires quarterly fire drills in all health care facilities of a hospital.			
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