STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150173	A. BUILDING 00 B. WING	06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL	5165 MCCARTY LN LAFAYETTE, IN 47905

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S0000	This visit was for a standard licensure survey. Facility Number: 011506 Survey Date: 6/18,19 & 20/2012 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor Lynnette Smith Medical Surveyor QA: claughlin 07/02/12	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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S0362	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F) (d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following: 6) Ensure that the hospital does the following: (A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants. Based on document review and employee interview, the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths.	S0362	The (1) death not reported to IOPO occurred in the Emergency Department. Corrective actions to address the deficiency include: Meeting with IOPO Professinal Services Coordinator to develop a	08/03/2012

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	Thus the facility failed to notify procurement organization of all potential organ donors. Findings: 1. Review of the contract between the hospital and the Indiana Organ Procurement Organization (IOPO) indicated the hospital shall provide "Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the hospital". 2. Review of the documentation presented failed to show all deaths were reported. Review of the 2011 IOPO Donation Compliance Report indicated 30 deaths occurred in July and only 29 deaths were reported. Thus the hospital failed to show evidence that all deaths were reported. 3. Interview with Employee A13 on June 18, 2012 at 2pm, and review of the IOPO contract documentation verified the information.		plan, which includes: · All ED and Respiratory Therapy staff members will watch an instructional video from the IOPO University website that addresses the specific reason our referral was missed. · Following the video, each staff member will take a quiz with a 100% pass rate required. This website requires staff log-in for participation, so tracking information will be provided to ED leadership. · In addition to this education, the following forums will be used to reinforce this education: o Agenda Item at upcoming staff meetings o Article in departmental newsletter o Huddle topic To prevent this deficiency from occurring again, IOPO education will be included as an annual ED competency.Responsible Individual: Susan Miller, Director Emergency ServicesAddendum: Compliance with corrective action plan will be monitored via the monthly IOPO feedback report.	

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S1014	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c) (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals. Based on observation, policy and procedure review, document review and staff interview, the facility failed to implement its policy and procedure related to drug storage for 1 of 7 (Surgical Department) areas toured. Findings: 1. While on tour of facility on 6/19/12 at approximately 11:41 AM, in the company of P12, P23, and P29, the following was observed in the Surgical Department Malignant Hyperthermia Cart: A. 30 vials/ampules of Dantrium 20mg/vial (Dantrolene). B. lacked 36 vials/ampules of Dantrium 20mg/vial (Dantrolene). 2. Policy titled, "Malignant Hyperthermia" was reviewed on 6/20/12 at approximately 12:16 PM, and indicated on pg. 3, under VI. Monitoring and Equipment section, point A. and 6. Drugs,	S1014	Deficiency was immediately corrected on 6/19/12, with the addition of 6 vials of Dantrolene. Contents of cart were rechecked to confirm was stocked in accordance with policy. Cart secured. To prevent reoccurrence, pharmacy staff will assume primary responsibility for the Malignant Hyperthremia Cart using an exchange kit approach, whereby surgery staff will contact pharmacy to receive an exchange insert when medications from the Cart have been used. In addition to surgical staff Cart checks, pharmacy will also add inspection of the Cart to their monthly inspections in the surgical areas. Pending full implementation and in the case replacement medications are not immediately available, surgery staff will contact pharmacy regarding the need for medications, document shortages via the surgery communication board, and notify the nurse manager who will ensure medication is restocked when available. Same process	06/21/2012

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	"Ensure that the following are available for immediate use in the OR (Operating Room) Suite...Dantrolene sodium IV (intravenous) - 36 ampules." 3. Review of Malignant Hyperthermia Cart list of items on 6/20/12 at approximately 12:20 PM indicated, drawer 1 was to contain 36 vials/ampules of Dantrolene Sodium 20mg/vial (Dantrium). 4. Personnel P29 was interviewed on 6/19/12 at approximately 11:41 AM and confirmed, the malignant hyperthermia cart was lacking 36 vials of Dantrium. There were 30 in the cart at the time of observation by surveyor. Facility policy and procedure was not followed related to this.		will be adopted in all surgical areas. Responsible Individual: Jason Lohr, Pharmacy Operations Manager, and Ann Keyes, Director Peri-operative Services Addendum: Deficiency was corrected on site. Full exchange kit implementation anticipated August 30th, 2012. Addendum: Pharmacy will assume responsibility for corrective action plan. Pharmacy will also assume responsibility for monitoring of compliance by adding the Cart check to the monthly OR rounding.	

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S1022	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. Based on observation, policy and procedure review, and staff interview, the facility failed to ensure appropriate storage conditions for high alert medications according to facility policy and procedure for 3 of 7 (Surgical Sterile Core, Emergency Department {ED}, Intensive Care Unit {ICU}) areas toured. Findings: 1. While on tour of facility on 6/19/12 at approximately 11:00 AM and 4:00 PM, in the company of P12, P23, P28, P29 and P30, the following was observed in the: A. Surgical Sterile Core Medication Refrigerator: a. high alert medications were not separated from the general medication inventory and/or lacked a high alert warning label on the storage bin. B. ED Trauma Room 4 Medication	S1022	High-risk medication storage corrections have been implemented in the secure Pyxis medication refrigerators in both the ED and ICU. Medications are now stored in red bins with high alert medication labels applied. (see photograph) Pharmacy leadership and the Medication Safety Committee will review the “High Risk or High Alert” policy to update the list of medications included and ensure adherence to stated policy requirements in all areas where high-risk / high-alert medications are stored. Responsible Individual: Jason Lohr, Pharmacy Operations Manager.Addendum: High-risk medication storage corrections were also implemented in the surgical sterile core medication refrigerator.	07/20/2012

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	Refrigerator: a. high alert medications were not separated from the general medication inventory and/or lacked a high alert warning label on the storage bin. C. ICU Medication Room Refrigerator: a. high alert medications were not separated from the general medication inventory and/or lacked a high alert warning label on the storage bin. 2. Policy titled, "High Risk or High Alert Medications" was reviewed on 6/20/12 at approximately 12:26 PM, and indicated on pg. 2, under Procedures section, points D., 1., e. and g., "All [facility] employees will be mindful of high alert medications. These medications will be sequestered and separated from the general medication inventory in a system that would reduce errors...Pharmacy will apply special auxiliary (High Alert) warning labels on the storage bins containing high alert medications." 3. Personnel P29 was interviewed on 6/19/12 at approximately 11:41 AM and confirmed high alert medications in the fridge in the [Surgical] Sterile Core were not stored according to facility policy and procedure because it was not separated from the general medication inventory in a system that would decrease medication errors and/or lacked a high alert warning			

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	label on the storage bin. 4. Personnel P30 was interviewed on 6/19/12 at approximately 11:07 AM and confirmed high alert medication Succinylcholine in the fridge in Trauma Room 4 was not stored according to facility policy and procedure because it was not separated from the general medication inventory in a system that would decrease medication errors and/or lacked a high alert warning label on the storage bin. 5. Personnel P28 was interviewed on 6/19/12 at approximately 4:00 PM and confirmed high alert medication Rocuronium in the Medication Room Fridge was not stored according to facility policy and procedure because it was not separated from the general medication inventory in a system that would decrease medication errors and/or lacked a high alert warning label on the storage bin.			