

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  08/27/2014
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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	The visit was for a Federal hospital re-certification survey.  Facility Number: 005041  Survey Date: 8-25/27-14  Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor  Linda Plummer, RN Public Health Nurse Surveyor  Steve Poore, BS MLT Medical Surveyor 3  QA: cloughlin 09/11/14	A000000		
A000117	482.13(a)(1) PATIENT RIGHTS: NOTICE OF RIGHTS A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. Based on document review and interview, the facility failed to develop and maintain its policy/procedures regarding notice of patient rights	A000117	Policy and Procedure has been developed to guide new processes that (1) on admission and all emergency room patients, will receive patient rights and	09/25/2014

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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	<p>including a provision for documenting when all patients and/or their representatives are provided with notice of patient rights prior to receiving or discontinuing care.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 8-25-14 at 1645 hours, the director of quality A4 was requested to provide an administrative or departmental policy/procedure regarding Notice of Patient Rights including the specific patients rights information or notice provided to all patients and/or their representative and indicating the process for documenting when, where, and how the notice of patient rights was provided by the designated department personnel and accepted or refused by the patient or the patient's representative and no policy/procedure was received prior to exit.</li> <li>2. During an interview on 8-26-14 at 1615 hours, the director of quality A4 confirmed that the facility failed to develop and maintain a policy/procedure regarding Notice of Patient Rights including the notice of all rights provided to patients and the process for providing the notice of patient rights.</li> <li>3. During an interview on 8-26-14 at</li> </ol>		<p>responsibilities statement from patient access. The patient or patient's representative will initial and sign that they have rejected or accepted the written statement. (2) The patient rights will be placed in the patient guide, also. Responsible party will be the Manager of Patient Access. The Manager will perform quarterly random chart reviews and report to the Quality Officer.</p>		

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	<p>1620 hours, the director of quality A4 confirmed that the Patient Guide and Information folder failed to indicate a patient bill of rights or list of patient rights and responsibilities.</p> <p>4. During an interview on 8-27-14 at 1120 hours, quality specialist A21 confirmed that no patient access [patient registration] policy indicated the responsibility of the patient access representative to provide the notice of patient rights during admission registration or indicated how to document when the notice of rights was received or refused by the patient.</p> <p>5. During an interview on 8-27-14 at 1245 hours, the patient access manager A23 indicated that the registration staff provide each patient with a 1 page document titled patient rights and responsibilities (no approval date) in the Patient Guide and Information folder. The manager A23 confirmed that the admitting process checklist titled Admits From Emergency Room failed to indicate or require staff to provide a notice of patient rights and responsibilities to the patient. The patient access manager A23 confirmed that no medical record documentation by admission staff was available to indicate that the notice of patient rights was received or refused by</p>			

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A000119	<p>the patient or representative.</p> <p>482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.</p> <p>Based on document review and interview, the governing board failed to ensure that the responsibility for the grievance review process was delegated to a grievance committee (composed of more than one person) or otherwise be directly responsible for reviewing and resolving grievances.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The Governing Board bylaws (reviewed 1-13), executive committee description and board quality council committee description failed to indicate a provision for reviewing and resolving grievances or delegating the grievance process to a grievance committee.</li> <li>The policy/procedure Patient Complaints/Grievances (revised 7-06)</li> </ol>	A000119	<p>The Board Bylaws have been amended to include a process for reviewing and resolving grievances. The bylaws state that a hospital grievance committee shall be responsible for this process. A grievance Policy and Procedure has been updated to reflect these changes. Recommended changes have been approved by the Board Bylaws Chairperson. These changes and revisions will be reviewed by the appropriate committees. All grievances will be reported to Board Quality quarterly. The Quality Officer will be responsible for these changes and processes.</p>	09/23/2014	

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A000133	<p>indicated the following: "the Board of Directors is responsible for assuring that an effective and efficient grievance resolution process is maintained ...[and] ... delegates authority to ...the Guest Relations Coordinator [who] shall provide written acknowledgement and resolution/response to complainants ..."</p> <p>3. During an interview on 8-27-14 at 1340 hours, the patient experience officer A22 confirmed that the Governing Board bylaws failed to indicate a provision for delegating the grievance process to a grievance committee and confirmed that the Patient Complaint/Grievance policy (revised 7-06) failed to indicate that patient grievances would be reviewed and resolved by a committee. The patient experience officer confirmed that they (A22) were the person responsible for reviewing and resolving all patient grievances at the facility.</p> <p>482.13(b)(4) PATIENT RIGHTS: ADMISSION STATUS NOTIFICATION The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital. Based on document review and interview, the facility failed to develop and maintain its policy/procedures and</p>	A000133	Patient access representative will ask patients being admitted if they would like a family member	09/25/2014			

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	<p>assure that a patient's family member or designated representative was promptly notified about the admission.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 8-25-14 at 1645 hours, the director of quality A4 was requested to provide an administrative or departmental policy/procedure regarding Notice of Patient Rights including the notification of a family member or representative of choice and the notification of his/her physician about the admission and no policy/procedure was received prior to exit.</li> <li>2. During an interview on 8-27-14 at 1120 hours, the quality specialist A21 confirmed that no administrative policy/procedure indicating a process for notifying a family member or representative of choice and notifying the patient's physician about the admission by a hospital representative was available.</li> <li>3. During an interview on 8-27-14 at 1255 hours, the patient access manager A23 confirmed that no patient access (registration) policy/procedure indicated a process for notifying a family member or representative of choice about the admission including a requirement for</li> </ol>		<p>or representative notified of their admission and patient access will document on the verbal communication form that will be kept in the patient's medical record. A new policy and procedure has been developed to guide these processes. The family physician will be notified by the emergency or covering physician and a list of patients and admissions per physician is compiled per electronic record. Responsible party will be the Manager of Patient Access. The Manager will perform quarterly random chart reviews and report to the Quality Officer.</p>		

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A000154	<p>documenting when requested or declined was available and the patient access manager A23 confirmed that no medical record documentation indicating that a family member or representative of choice was notified by a patient access staff about the admission was available.</p> <p>482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.</p> <p>Based on policy and procedure review, medical record review, and staff interview, the nursing executive failed to ensure implementation of the policy related to restraint monitoring for two of two patients restrained (pts. #8 and #9).</p> <p>Findings: 1. Review of the policy and procedure "Restraints", no policy number, last reviewed on 5/15/14, indicated: a. On page 8, under "Patient Assessment, Monitoring, &amp; Documentation", it reads: "...3. Every</p>	A000154	All clinical nurses will have mandated education, during skills validation regarding patient restraints with competency testing (written and demonstration) that will include every 2 hour documentation, restraint orders, and timing of charting. Clinical nurses will perform chart audits on all restraint charts and report to the Quality Officer after each restraint event. The Quality Officer is the responsible party for monitoring and compliance.	09/23/2014

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	<p>two hours document: a. Extremity assessments b. Assistance with toileting c. Provision of nutrition and fluids d. Release of restraints and ROM (range of motion) of affected extremity e. Mental/behavior status. For Management of Violent or Self-Destructive Behavior:...If the patient's behavior requiring restraint application improves, the RN (registered nurse), thorough assessment monitoring and reevaluation of the patient, may discontinue the restraints prior to the expiration of the order or at the earliest possible time. If restraints are discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying the restraints."</p> <p>2. Review of medical records for two patients, who had been in ICU, indicated:</p> <p>a. Pt. #8 had physician orders for medical restraints (pt. dislodging endotracheal tube and pulling out IV [intravenous] line) on 12/11/13, 12/12/13, 12/13/13, and 12/14/13 with every two hour documentation lacking as follows:</p> <p>A. On 12/11/13 between 2:17 AM and 4:24 AM = 7 min. late; 6:09 AM to 9:07 AM was 58 minutes late; 9:07 AM to 1:29 PM was 2 hours and 22 minutes late for restraint checks; 1:29 PM to 8:54 PM was a 7 hour and 25 minute lapse in</p>			

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	<p>nursing documentation.</p> <p>B. On 12/12/13 between 4:03 AM and 6:20 AM was 17 min. late; between 6:20 AM to 9:32 AM was a 1 hour and 12 minute delay; between 9:32 AM and 3:53 PM was a 6 hr and 21 minute lapse in charting; and between 3:53 PM and 6:45 PM was a 52 minute delay in charting.</p> <p>C. On 12/13/13, between 2:30 AM and 7:30 AM, there was a 5 hour gap in nursing restraint documentation; and between 7:30 AM and 11:50 AM, a 2 hour and 20 minute delay.</p> <p>D. On 12/14/13, between 8:40 AM and 12:00 PM was a 1 hour and 20 minute gap; between 12:00 PM and 3:40 PM was a 1 hour and 40 minute delay; and between 6:07 PM and 8:54 PM was a 47 minute delay in nursing documentation.</p> <p>b. Pt. #9 had physician orders for medical restraints on 1/4/14 due to pulling out their NG (nasogastric) tube and dislodging their endotracheal tube. Every two hour documentation while the patient was in restraint was lacking as follows:</p> <p>A. On 1/4/14, between 5:45 AM and 8:20 AM, was a 35 minute lapse; between 8:20 AM and 10:30 AM was a 10 minute gap, and between 10:30 AM and 12:40 PM was a 10 minute gap.</p> <p>B. A note written by nursing at 10:30 AM states: "Restraints have been off since 1000".</p>			

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A000358	<p>C. Documentation of restraints noting "loosened" was written at 12:40 PM, 1:40 PM, and 2:00 PM, with no new order for restraints found in the medical record.</p> <p>3. At 2:00 PM on 8/27/14, interview with staff member #50, the director of quality, indicated:</p> <p>a. As listed in 10. above, nursing failed to follow facility policy related to restraints, with the lack of every two hour documentation related to restraints as required by facility policy.</p> <p>b. Pt. #9 lacked a new order for restraints when nursing noted that restraints were released at 10:00 AM on 1/4/14, and then began documenting restraint activity again at 12:40 PM without a new order.</p> <p>482.22(c)(5)(i) MEDICAL STAFF RESPONSIBILITIES [ The bylaws must:]</p> <p>Include a requirement that--</p> <p>(i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and</p>						

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	<p>documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy.</p> <p>Based on review of the medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure that a history and physical was performed within 24 hours of admission for 1 of 2 pediatric patients (pt. #11).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the medical staff rules and regulations, last approved 5/17/13, indicated: <ol style="list-style-type: none"> <li>Under section "III. Medical Records, Documentation", it reads: "...4. A complete history and physical exam must, in all cases, be written or dictated no more than thirty (30) days before or within 24 hours after admission of patient...".</li> </ol> </li> <li>Review of closed pediatric medical records indicated: <ol style="list-style-type: none"> <li>Pt. #11 was admitted to the ICU (intensive care unit) at 12:01 AM on 6/3/14 and had a history and physical dictated at 7:56 AM on 6/4/14.</li> </ol> </li> <li>Interview with staff member #50, the facility director of quality, at 2:00 PM on 8/27/14, indicated:</li> </ol>	A000358	The Physician chairman for Medical Staff has re-educated medical staff on history and physical requirements for completion. Quality audits will be performed by Health Information Management and reported to Board Quality, quarterly. The Director of HIM will be responsible for compliance of quality reporting. The CMO will be responsible for compliance of meeting the standard for history and physical completion.	09/09/2014			

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A000386	<p>a. The history and physical for pt. #11 was not within 24 hours of admission, it would need to have been dictated between midnight (12:01 AM) on 6/3/14 and midnight on 6/4/14--it is almost 8 hours beyond the 24 hours requirement.</p> <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, medical record review, observation, and staff interview, the nursing executive failed to: ensure implementation of the policy related to the refrigerator log; ensure the blanket warmer log was completed daily, as per expectations; and failed to ensure implementation of the policy related to the marking of glucometer test strips and control solutions once opened.</p> <p>Findings: 1. Review of the policy and procedure "Refrigerator/Patient Log", no policy</p>	A000386	All clinical nurses will have mandated education, during skills validation regarding refrigerator and blanket warmer temperature logs with review of current refrigerator policy and new blanket warmer policy. Clinical nurses will perform log audits on all refrigerator and blanket temperature logs and report to Quality Officer monthly. All Unit Directors are responsible for compliance. A policy and procedure has been developed for blanket warmers. Glucometer strips and control solutions policy and practices will be reviewed at skills validation. Index cards will be taped to all accu-check	09/23/2014			

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	<p>number noted, with a last reviewed date of 7/11/13, indicated:</p> <p>a. The first line of the policy reads: "The inside temperature of the refrigerators shall be checked and logged daily...".</p> <p>2. At 2:40 PM on 8/25/14, while on tour of the ICU (intensive care unit) in the company of staff member #53, the ICU nurse manager, it was observed that the pantry/patient refrigerator log sheet for temperature checks lacked:</p> <p>a. Documentation for 28 of 31 days in July 2014.</p> <p>b. Documentation for 11 of 25 days, to date, for August 2014.</p> <p>3. Interview with staff member #53 at 2:40 PM on 8/25/14 indicated agreement that the nursing staff was not completing the refrigerator temperature log daily, as required per facility policy.</p> <p>4. At 2:45 PM on 8/25/14, while on tour of the ICU in the company of staff member #53, the ICU nurse manager, it was observed that the blanket warmer temperature log:</p> <p>a. Lacked documentation of a daily temperature for 18 of 25 days, to date, for August 2014.</p>		<p>machines with instructions for dating and labeling solutions and strips according to hospital policy. The clinical directors will be responsible for compliance.</p>		

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	<p>b. Lacked documentation of a daily temperature for 13 of 31 days in July 2014.</p> <p>5. Interview with staff member #53 at 2:45 PM on 8/25/14 indicated nursing staff was not documenting daily temperature checks.</p> <p>6. At 4:15 PM on 8/26/14, interview with staff member #50, the director of quality, indicated there is no facility policy related to documentation required for daily blanket warmer temperature checks, but that is the facility expectation.</p> <p>7. At 10:42 AM on 8/26/14, while on tour of the pre/post op area in the company of staff member #54, the nursing surgery director, it was observed that the pantry/patient refrigerator lacked documentation of temperature checks for:</p> <p>a. Five days in August 2014, between August 1 and August 25.</p> <p>b. One day in July, 2014.</p> <p>8. Interview with staff member #54 at 10:45 AM on 8/26/14 indicated confirmation of dates missing for documentation of refrigerator temperatures as listed in 7. above.</p> <p>9. Review of the glucometer test strip</p>						

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	<p>package insert from the manufacturer indicated that the test strips are good to the expiration date on the vial, even after opening.</p> <p>10. Review of the facility policy and procedure "Glucose Monitoring: Accu-Chek Inform Proficiency Testing", with no policy number, and dated with a last revised date of 6/18/13, indicated:</p> <p>a. Under "Quality Control", on page two, it reads: "Quality control material must be appropriate for the type of assay strips in use. Store Q.C. (quality control) material and test strips at room temperature...Q.C. material is stable for 3 months once opened. Opened reagent strips are stable until the expiration date indicated on the bottle. Upon opening a new bottle of Q.C. material, document the date it was put into use, the expiration date is 3 months from opened for Q.C. material...".</p> <p>11. At 1:45 PM on 8/25/14, while on tour of the ED (emergency department) in the company of staff member #52, the ED nurse manager, it was observed that the glucometer test strips were dated with a 30 day expiration date after opened.</p> <p>12. At 2:55 PM on 8/25/14, while on tour of the ICU in the company of staff member #53, the nurse manager of the</p>						

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A000749	<p>unit, it was observed that the glucometer test strips were dated with a 30 day expiration date after opened.</p> <p>13. At 3:00 PM on 8/25/14, interview with staff member #53 indicated staff are dating a 30 day expiration date on glucometer test strips which is incorrect as the manufacturer indicates they are good to the expiration date on the viall, which was 5/2015.</p> <p>14. At 11:15 AM on 8/26/14, while on tour of the newborn nursery in the company of staff member #55, the nurse manager of the unit, it was observed that two sets of glucometer control solutions (4 vials total) lacked a documentation on the vials of the date opened, or the 90 day expiration date once opened, per facility policy.</p> <p>15. Interview with staff member #55 at 11:20 AM on 8/26/14 indicated there was no notation on the four glucometer control solutions indicating when they had been opened so that nursing staff would know when the 90 day expiration date would occur.</p>						

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	<p><b>INFECTION CONTROL PROGRAM</b> 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, employee health file review, and staff interview, the infection control committee failed to ensure that the policy related to TST (tuberculin skin testing) was implemented for 3 of 12 employees (staff members N1, N7, and N12).</p> <p>Findings:</p> <p>1. Review of the Exposure Control Plan, specifically regarding "Tuberculosis Exposure Control Plan", with a policy number "TB ECP (exposure control plan)", with an effective date of 1988, indicated:</p> <p>a. On page 7, it reads: "...f. All TST's shall be administered, read, and interpreted by personnel specifically trained and certified in administration and interpretation of the Mantoux Skin Test...2) Skin test results will be read in 48 - 72 hours...".</p> <p>2. Review of employee health files indicated:</p> <p>a. Staff member N1 had a TST given on 11/20/13 that was read on 11/22/13, the time of the reading was not documented making it unknown if this</p>	A000749	Human Resources and the Employee Health nurse will review current TB policy and procedure for employee health files. Completion and management of TB testing with appropriate documentation will be audited for all new hires and reported to the Quality Officer on a monthly basis. There is a scheduled recertification class for TB testing (administration and reading). 2014. The Employee Health Nurse is responsible for compliance and quality reporting.	09/23/2014

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S000000	<p>reading was within the 48 to 72 hour time frame.</p> <p>b. Staff member N7 was given a TST on 4/13/14 but did not have the time noted in the area for "Date/time/given by:".</p> <p>c. Staff member N12 was given a TST on 8/26/13 but did not have the time noted in the area for "Date/time/given by:".</p> <p>3. At 2:35 PM on 8/27/14, interview with staff member #60, a human resource assistant, indicated:</p> <p>a. After review of the TST documentation for employees N1, N7 and N12, it was noted that no time given, or read, was documented for the TSTs for these staff members as written in 2. above.</p> <p>b. It cannot be determined that the TSTs were given, or read, within the 48 to 72 hour time frame with the lack of documentation.</p> <p>The visit was for a licensure survey.</p> <p>Facility Number: 005041</p> <p>Survey Date: 8-25/27-14</p>	S000000			

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S000178	<p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Steve Poore, BS MLT Medical Surveyor 3</p> <p>QA: cloughlin 09/11/14</p> <p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and interview, the facility failed to ensure the posting of the hospital license at two of two off site locations toured.</p> <p>Findings: 1. At 8:55 AM on 8/27/14, while on tour of the Garrett, Indiana off site lab location in the company of staff member</p>	S000178	The hospital license has been posted in the Butler and Garrett clinics in the reception room for patients and the public to view. The VP of Physician Strategy will be responsible for compliance.	09/22/2014			

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S000306	<p>#62, the lab tech working at the facility, it was observed that there was no posting of the hospital license at this location.</p> <p>2. At 9:00 AM on 8/27/14, interview with staff member #62, the lab technician, indicated that they agreed there was no hospital license posted at the off site facility.</p> <p>3. At 9:45 AM on 8/27/14, while on tour of the Butler, Indiana off site lab location in the company of staff member #63, the lab tech working at the facility, it was observed that there was no posting of the hospital license at this location.</p> <p>4. At 9:50 AM on 8/27/14, interview with staff member #63, the lab technician, indicated that they agreed there was no hospital license posted at this off site lab facility.</p> <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</p>						

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	<p>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. Based on document review, employee file review, and staff interview, the human resources department failed to implement policies related to background checks for 3 of 12 files reviewed (staff members N5, N6, and N12).</p> <p>Findings: 1. Review of the policy and procedure "Limited Criminal History of Employees", policy number XIII-008, with a last date revised/reviewed of 03/01/11, indicated: a. The second paragraph reads: "The Hospital as (sic) selected Barada Associates as its vendor to conduct verification of employment inquiries, a limited criminal history investigation as well as Social Security number verification." b. The third paragraph reads: "At the time an offer of employment is made, Human Resources will submit a request to Barada Associates to conduct a background check. All offers of</p>	S000306	The Director of Human Resources is updating the policy and procedure on new employee hires and background checks. Audits will be performed on all new hires for completion of hiring practices including background checks and reported to the Quality Officer on a quarterly basis. The Director of Human Resources will be responsible for compliance.	09/26/2014

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	<p>employment are contingent upon the results of this background investigation by Barada Associates...".</p> <p>c. The last paragraph reads: "...Within 3 days of employment, the Registry (previously named as Indiana State Nurse Aide Registry) will be checked for negative findings on any nurse aide...If no record is found, that information will be noted in the personnel file of the individual along with the date and name of the individual making the inquiry."</p> <p>2. Review of the job description for monitor techs indicated that, among other patient care duties, the technician: "...10. Assists nursing staff members with bathing, moving, and lifting patients...".</p> <p>3. Review of employee files indicated:</p> <p>a. Staff member N5 was a RN (registered nurse) hired 10/28/13 who lacked documentation from the Barada Associates indicating that a background check was performed.</p> <p>b. Staff member N6 was a monitor tech hired 10/14/13, who lacked documentation of having the state's nurse aide registry site checked.</p> <p>c. Staff member N12 was a nurse aide hired 8/19/13 who lacked documentation from the Barada Associates indicating that a background check was performed.</p>			

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S000308	<p>4. Interview with staff member #51, the vice president of patient services, at 11:15 AM on 8/27/14, indicated:</p> <p>a. There was no Barada Associates background check information in the personnel file for staff member N5.</p> <p>b. The facility requires that all nursing support staff, including a monitor tech such as N6, are to have the nurse aide registry check performed.</p> <p>c. It was noted that the contact information listed in the policy, related to nurse aide registry checks, is no longer current.</p> <p>5. Interview with staff member #60, the human resources staff member, at 12:15 PM on 8/27/14, indicated:</p> <p>a. There was no Barada Associates background check information in the employee file for staff members N5 and N12.</p> <p>b. It was unknown why the background checks were not performed, as per facility policy, for staff members N5 and N12, as both had signed the proper forms giving permission for this background check to be performed at the time of hire.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</p> <p>(c) The governing board is responsible</p>						

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	<p>for managing the hospital. The governing board shall do the following:</p> <p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on employee file review and interview, department specific orientation was lacking for 3 of 12 employees (staff members N1, N3, and N4).</p> <p>Findings:</p> <p>1. Review of employee files indicated:</p> <p>a. Staff member N1 was a medical assistant hired 11/11/13, who lacked any documentation of department specific orientation at the time of hire.</p> <p>b. Staff member N3 was hired 12/2/13 as a medical assistant, and changed 5/19/14 to the CBO (central billing office), and lacked department orientation for either position.</p> <p>c. Staff member N4 was a finance employee hired 11/11/13, who lacked any documentation of department specific orientation at the time of hire.</p> <p>2. Interview with staff member #64, a director of physician offices/ancillary services, at 12:10 PM on 8/27/14,</p>	S000308	<p>Specific unit orientation is being reviewed and updated with a form for signatures to validate competency completion by Central Business Office (CBO) and DeKalb Health Medical Group (DHMG). CBO and DHMG will develop a policy and procedure for unit specific orientation. Audits will be performed on new hires for completion of unit specific orientation and reported to the Quality Officer quarterly. The Director of CBO and the VP of DHMG will be responsible for completion.</p>	09/26/2014

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	<p>indicated:</p> <p>a. There currently is no documentation of any training that takes place at the time of hire for the off site medical assistants, including N1 and N3.</p> <p>3. Interview with staff member #51, the vice president of patient services, at 11:15 AM on 8/27/14, indicated:</p> <p>a. Each unit/department is expected to be doing their own department specific orientation, and should have a policy/procedure related to what is to be instructed, and the expected time frame for orientation to that specific department.</p> <p>4. At 12:05 PM on 8/27/14, interview with staff member #61, the CBO director, indicated:</p> <p>a. There is currently no department policy and procedure related to the orientation of new staff specific to that department.</p> <p>b. Staff member N1 was hired 11/11/13, had an orientation document with a "created" date of 3/13/14 that was signed off by this staff member, but lacked a date by this staff member of the actual orientation completion.</p> <p>c. It is expected that orientation will be accomplished within 30 days of hire and staff member N1 did not have their orientation done within this time frame.</p>						

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S000322	<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: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based upon document review and interview, the facility failed to maintain its policy/procedures and ensure that all policies and procedures were reviewed and updated at least triennially.</p> <p>Findings:</p> <p>1. The policy/procedure titled Policies &amp; Procedures New/Revised (revised 3-14) indicated the following: "...all policies and procedures shall be reviewed every three (3) years ...it shall be the responsibility of the department managers to ensure that policies falling under their authority are maintained in a timely manner ...contain current information and are readily available ..."</p>	S000322	The Medical Records policy and procedures; signature stamp policy , validating the sign-out box, and charging for ROI requests patient and related requests have been updated, revised and placed into electronic policy and procedure (MCN). The Director of HIM will be responsible for compliance of updating and maintaining HIM policies and procedures and converting all policies to electronic format by 9/26/14. The following policies have been addressed as indicated: Patient rights/ responsibilities and complaints / grievances have been updated and are going through the approval processes. The Patient Experience Officer will be responsible for compliance. New employee orientation and limited criminal	09/26/2014	

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	<p>2. The Medical Records (MR) policy/procedures Accessibility to the Medical Records Department (approved 12-10), Signature Stamp Policy (approved 12-10), Validating the Sign-out Box (approved 12-10) and Charging for ROI Requests for the Patient and Related Requests (approved 12-10) failed to indicate they were updated and reviewed within the last 3 years.</p> <p>3. During an interview on 8-25-14 at 1645 hours, the director of quality A4 indicated in 2012 that the facility began transforming its policies and procedures from a paper format to an electronic policy management system. The director of quality A4 confirmed that the MR policies and procedures had not been maintained and had not been converted to the electronic format utilized by the policy management system.</p> <p>4. During an interview on 8-27-14 at 0935 hours, the health information systems director A13 confirmed that the MR policy/procedures had not been maintained.</p> <p>5. The policy/procedures Confidentiality (revised 11-07), Patient Complaints/Grievances (revised 7-06), Consent to Treat (reviewed 10-07),</p>		<p>history of employee policies have been reviewed and revised as of 9/26/2014. The Director of HR will be responsible for compliance. The consent to treat and the consent procedure will be reviewed and revised as of 9/26/2014. The Manager of Patient Access will be responsible for compliance. All above policies are to be approved, completed and placed into the electronic policy and procedure format as of 9/26/14. Responsibilities are as individually assigned above.</p>		

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S000604	<p>Consent Procedure (reviewed 7-09), New Employee Orientation (reviewed 3-11), Limited Criminal History of Employees (reviewed 3-11), Patient Bill of Rights (approved 7-2000) and Patient Rights and Responsibilities (no approval date) provided for surveyor review failed to indicate they were updated and reviewed within the last 3 years.</p> <p>6. During an interview on 8-27-14 at 1320 hours, the director of quality A4 confirmed that the policy/procedures failed to indicate that they had been updated and reviewed in accordance with facility policy.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vii)</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>(vii) A system, which complies with state and federal law, to monitor the immune status of health care workers</p>			

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	<p>exposed to communicable diseases. Based on policy and procedure review, employee health file review, and staff interview, the infection control committee failed to ensure that the policy related to TST (tuberculin skin testing) was implemented for 3 of 12 employees (staff members N1, N7, and N12).</p> <p>Findings:</p> <p>1. Review of the Exposure Control Plan, specifically regarding "Tuberculosis Exposure Control Plan", with a policy number "TB ECP (exposure control plan)", with an effective date of 1988, indicated:</p> <p>a. On page 7, it reads: "...f. All TST's shall be administered, read, and interpreted by personnel specifically trained and certified in administration and interpretation of the Mantoux Skin Test...2) Skin test results will be read in 48 - 72 hours...".</p> <p>2. Review of employee health files indicated:</p> <p>a. Staff member N1 had a TST given on 11/20/13 that was read on 11/22/13, the time of the reading was not documented making it unknown if this reading was within the 48 to 72 hour time frame.</p> <p>b. Staff member N7 was given a TST on 4/13/14 but did not have the time</p>	S000604	Human Resources and the Employee Health nurse will review current TB policy and procedure for employee health files. Completion and management of TB testing with appropriate documentation will be audited for all new hires and reported to the Quality Officer on a monthly basis. There is a scheduled recertification class for TB testing (administration and reading). The Employee Health Nurse is responsible for compliance and quality reporting.	09/23/2014			

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S000672	<p>noted in the area for "Date/time/given by:".</p> <p>c. Staff member N12 was given a TST on 8/26/13 but did not have the time noted in the area for "Date/time/given by:".</p> <p>3. At 2:35 PM on 8/27/14, interview with staff member #60, a human resource assistant, indicated:</p> <p>a. After review of the TST documentation for employees N1, N7 and N12, it was noted that no time given, or read, was documented for the TSTs for these staff members as written in 2. above.</p> <p>b. It cannot be determined that the TSTs were given, or read, within the 48 to 72 hour time frame with the lack of documentation.</p> <p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(e)</p> <p>(e) All nursing and other hospital personnel performing out-of-laboratory testing shall have annually updated performance certification maintained in the employee file for the procedures being performed.</p> <p>Based on document review and interview, the facility failed to ensure that off site medical assistants were trained to perform point of care testing, and failed</p>	S000672	DeKalb Health Medical Group (DHMG) will train techs for all point of care testing and document competencies. This will be part of new hire unit	09/26/2014

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	<p>to document skills competency for the tests performed, for 2 of 2 medical assistants (staff members N1 and N3).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the job description for medical assistants indicated employees in this position are allowed to perform "lab testing", including point of care testing, such as blood glucose checks.</li> <li>2. Review of employee files indicated: <ol style="list-style-type: none"> <li>a. Staff member N1 was a medical assistant hired 11/11/13 who lacked documentation in their personnel file regarding training, and skills competency, for performing point of care testing, such as blood glucose checks.</li> <li>b. Staff member N3 was a medical assistant hired 12/2/13 who lacked documentation in their personnel file regarding training, and skills competency, for performing point of care testing, such as blood glucose checks. (This staff member changed positions on 5/19/14.)</li> </ol> </li> <li>3. At 10:40 AM on 8/27/14, interview with staff member #58, the lab director, indicated: <ol style="list-style-type: none"> <li>a. There currently is no training of the off site medical assistants related to lab duties, including point of care testing and skills competency for these duties, that would be overseen by the main hospital</li> </ol> </li> </ol>		<p>specific training and will be placed in the policy and procedure developed for unit specific orientation. Audits will be performed on new hires for point of care testing and documented competencies and will be reported to the Quality Officer quarterly. The VP of DHMG will be responsible for completion.</p>		

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S000751	<p>lab staff.</p> <p>4. Interview with staff member #64, a director of physician offices/ancillary services, at 12:10 PM on 8/27/14, indicated:</p> <p>a. There currently is no documentation of training of the off site medical assistants related to lab duties, including point of care testing, and skills competency for these duties.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(2)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(2) The medical history and physical examination of the patient done within the time frames as prescribed by the medical staff rules and section 5 (b)(3)(M) of this rule.</p> <p>Based on review of the medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure that a history and physical was performed within 24 hours of admission for 1 of 2 pediatric patients (pt. #11).</p>	S000751	<p>The Physician chairman for Medical Staff has re-educated medical staff on history and physical requirements for completion.</p> <p>Quality audits will be performed by Health Information Management and reported to</p>	09/09/2014

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S000912	<p>Findings:</p> <p>1. Review of the medical staff rules and regulations, last approved 5/17/13, indicated:</p> <p>a. Under section "III. Medical Records, Documentation", it reads: "...4. A complete history and physical exam must, in all cases, be written or dictated no more than thirty (30) days before or within 24 hours after admission of patient...".</p> <p>2. Review of closed pediatric medical records indicated:</p> <p>a. Pt. #11 was admitted to the ICU (intensive care unit) at 12:01 AM on 6/3/14 and had a history and physical dictated at 7:56 AM on 6/4/14.</p> <p>3. Interview with staff member #50, the facility director of quality, at 2:00 PM on 8/27/14, indicated:</p> <p>a. The history and physical for pt. #11 was not within 24 hours of admission, it would need to have been dictated between midnight (12:01 AM) on 6/3/14 and midnight on 6/4/14--it is almost 8 hours beyond the 24 hours requirement.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p>		Board Quality, quarterly. The Director of HIM will be responsible for compliance of quality reporting. The CMO will be responsible for compliance of meeting the standard for history and physical completion.		

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	<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, medical record review, observation, and staff interview, the nursing executive failed to: ensure implementation of the policy related to the refrigerator log; ensure the blanket warmer log was completed daily, as per expectations; failed to ensure the implementation of the policy related to restraint monitoring for</p>	S000912	All clinical nurses will have mandated education during skills validation regarding refrigerator and blanket warmer temperature logs with review of current refrigerator policy and new blanket warmer policy. Clinical nurses will perform log audits on all refrigerator and blanket temperature logs and report to Quality Officer monthly. All Unit	09/23/2014			

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	<p>two of two patients restrained (pts. #8 and #9); and failed to ensure implementation of the policy related to the marking of glucometer test strips and control solutions once opened.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the policy and procedure "Refrigerator/Patient Log", no policy number noted, with a last reviewed date of 7/11/13, indicated: <ol style="list-style-type: none"> <li>The first line of the policy reads: "The inside temperature of the refrigerators shall be checked and logged daily...".</li> </ol> </li> <li>At 2:40 PM on 8/25/14, while on tour of the ICU (intensive care unit) in the company of staff member #53, the ICU nurse manager, it was observed that the pantry/patient refrigerator log sheet for temperature checks lacked: <ol style="list-style-type: none"> <li>Documentation for 28 of 31 days in July 2014.</li> <li>Documentation for 11 of 25 days, to date, for August 2014.</li> </ol> </li> <li>Interview with staff member #53 at 2:40 PM on 8/25/14 indicated agreement that the nursing staff was not completing the refrigerator temperature log daily, as required per facility policy.</li> </ol>		<p>Directors are responsible for compliance. A policy and procedure has been developed for blanket warmers. Glucometer strips and control solutions policy and practices will be reviewed at skills validation. Index cards will be taped to all accu-check machines with instructions for dating and labeling solutions and strips according to hospital policy. The clinical directors will be responsible for compliance. All clinical nurses will have mandated education, during skills validation regarding patient restraints with competency testing (written and demonstration) that will include every 2 hour documentation, restraint orders, and timing of charting. Clinical nurses will perform chart audits on all restraint medical charts and reported to Quality Officer after each restraint event.</p>		

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	<p>4. At 2:45 PM on 8/25/14, while on tour of the ICU in the company of staff member #53, the ICU nurse manager, it was observed that the blanket warmer temperature log:</p> <p>a. Lacked documentation of a daily temperature for 18 of 25 days, to date, for August 2014.</p> <p>b. Lacked documentation of a daily temperature for 13 of 31 days in July 2014.</p> <p>5. Interview with staff member #53 at 2:45 PM on 8/25/14 indicated nursing staff was not documenting daily temperature checks.</p> <p>6. At 4:15 PM on 8/26/14, interview with staff member #50, the director of quality, indicated there is no facility policy related to documentation required for daily blanket warmer temperature checks, but that is the facility expectation.</p> <p>7. At 10:42 AM on 8/26/14, while on tour of the pre/post op area in the company of staff member #54, the nursing surgery director, it was observed that the pantry/patient refrigerator lacked documentation of temperature checks for:</p> <p>a. Five days in August 2014, between August 1 and August 25.</p>			

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	<p>b. One day in July, 2014.</p> <p>8. Interview with staff member #54 at 10:45 AM on 8/26/14 indicated confirmation of dates missing for documentation of refrigerator temperatures as listed in 7. above.</p> <p>9. Review of the policy and procedure "Restraints", no policy number, last reviewed on 5/15/14, indicated:                      a. On page 8, under "Patient Assessment, Monitoring, &amp; Documentation", it reads: "...3. Every two hours document: a. Extremity assessments b. Assistance with toileting c. Provision of nutrition and fluids d. Release of restraints and ROM (range of motion) of affected extremity e. Mental/behavior status. For Management of Violent or Self-Destructive Behavior:...If the patient's behavior requiring restraint application improves, the RN (registered nurse), thorough assessment monitoring and reevaluation of the patient, may discontinue the restraints prior to the expiration of the order or at the earliest possible time. If restraints are discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying the restraints."</p> <p>10. Review of medical records for two</p>			

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	<p>patients, who had been in ICU, indicated:</p> <p>a. Pt. #8 had physician orders for medical restraints (pt. dislodging endotracheal tube and pulling out IV [intravenous] line) on 12/11/13, 12/12/13, 12/13/13, and 12/14/13 with every two hour documentation lacking as follows:</p> <p>A. On 12/11/13 between 2:17 AM and 4:24 AM = 7 min. late; 6:09 AM to 9:07 AM was 58 minutes late; 9:07 AM to 1:29 PM was 2 hours and 22 minutes late for restraint checks; 1:29 PM to 8:54 PM was a 7 hour and 25 minute lapse in nursing documentation.</p> <p>B. On 12/12/13 between 4:03 AM and 6:20 AM was 17 min. late; between 6:20 AM to 9:32 AM was a 1 hour and 12 minute delay; between 9:32 AM and 3:53 PM was a 6 hr and 21 minute lapse in charting; and between 3:53 PM and 6:45 PM was a 52 minute delay in charting.</p> <p>C. On 12/13/13, between 2:30 AM and 7:30 AM, there was a 5 hour gap in nursing restraint documentation; and between 7:30 AM and 11:50 AM, a 2 hour and 20 minute delay.</p> <p>D. On 12/14/13, between 8:40 AM and 12:00 PM was a 1 hour and 20 minute gap; between 12:00 PM and 3:40 PM was a 1 hour and 40 minute delay; and between 6:07 PM and 8:54 PM was a 47 minute delay in nursing documentation.</p> <p>b. Pt. #9 had physician orders for</p>			

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	<p>medical restraints on 1/4/14 due to pulling out their NG (naso gastric) tube and dislodging their endotracheal tube. Every two hour documentation while the patient was in restraint was lacking as follows:</p> <p>A. On 1/4/14, between 5:45 AM and 8:20 AM, was a 35 minute lapse; between 8:20 AM and 10:30 AM was a 10 minute gap, and between 10:30 AM and 12:40 PM was a 10 minute gap.</p> <p>B. A note written by nursing at 10:30 AM states: "Restraints have been off since 1000".</p> <p>C. Documentation of restraints noting "loosened" was written at 12:40 PM, 1:40 PM, and 2:00 PM, with no new order for restraints found in the medical record.</p> <p>11. At 2:00 PM on 8/27/14, interview with staff member #50, the director of quality, indicated:</p> <p>a. As listed in 10. above, nursing failed to follow facility policy related to restraints, with the lack of every two hour documentation related to restraints as required by facility policy.</p> <p>b. Pt. #9 lacked a new order for restraints when nursing noted that restraints were released at 10:00 AM on 1/4/14, and then began documenting restraint activity again at 12:40 PM without a new order.</p>			

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	<p>12. Review of the glucometer test strip package insert from the manufacturer indicated that the test strips are good to the expiration date on the vial, even after opening.</p> <p>13. Review of the facility policy and procedure "Glucose Monitoring: Accu-Chek Inform Proficiency Testing", with no policy number, and dated with a last revised date of 6/18/13, indicated: a. Under "Quality Control", on page two, it reads: "Quality control material must be appropriate for the type of assay strips in use. Store Q.C. (quality control) material and test strips at room temperature...Q.C. material is stable for 3 months once opened. Opened reagent strips are stable until the expiration date indicated on the bottle. Upon opening a new bottle of Q.C. material, document the date it was put into use, the expiration date is 3 months from opened for Q.C. material...".</p> <p>14. At 1:45 PM on 8/25/14, while on tour of the ED (emergency department) in the company of staff member #52, the ED nurse manager, it was observed that the glucometer test strips were dated with a 30 day expiration date after opened.</p> <p>15. At 2:55 PM on 8/25/14, while on tour of the ICU in the company of staff</p>				

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S001184	<p>member #53, the nurse manager of the unit, it was observed that the glucometer test strips were dated with a 30 day expiration date after opened.</p> <p>16. At 3:00 PM on 8/25/14, interview with staff member #53 indicated staff are dating a 30 day expiration date on glucometer test strips which is incorrect as the manufacturer indicates they are good to the expiration date on the viall, which was 5/2015.</p> <p>17. At 11:15 AM on 8/26/14, while on tour of the newborn nursery in the company of staff member #55, the nurse manager of the unit, it was observed that two sets of glucometer control solutions (4 vials total) lacked a documentation on the vials of the date opened, or the 90 day expiration date once opened, per facility policy.</p> <p>18. Interview with staff member #55 at 11:20 AM on 8/26/14 indicated there was no notation on the four glucometer control solutions indicating when they had been opened so that nursing staff would know when the 90 day expiration date would occur.</p> <p>410 IAC 15-1.5-8</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(2)</p> <p>(f) The safety management program shall include, but not be limited to, the following:</p> <p>(2) A safety committee appointed by the chief executive officer that includes representatives from administration, patient services, and support services. Based upon document review and interview, the safety committee failed to follow its safety management plan and conduct quarterly committee meetings for 3 of 5 quarters in 2013 and 2014.</p> <p>Findings:</p> <p>1. The policy/procedure Safety/EOC Management Plan (approved 5-13) indicated the following: "The Safety/EOC Committee shall meet at least quarterly."</p> <p>2. The EOC/Safety committee minutes provided for review indicated that the committee met on 8-01-13 and 4-10-14. No documentation indicated that the committee met during the 4th quarter of 2013 or 1st quarter 2014.</p> <p>3. The EOC/Safety committee minutes dated 4-10-14 indicated the following: "The committee agreed that they would</p>	S001184	An EOC Safety committee has been scheduled and the subsequent EOC Safety committee meetings will be scheduled after each quarterly quality council meeting to assure compliance. The Director of Plant Operations will be responsible for compliance.	09/26/2014

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  08/27/2014
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	<p>meet quarterly on the 3rd Thursday at 9:00 AM." No documentation provided for review indicated that the committee met on 7-17-14 or on 8-21-14 as suggested by the meeting minutes.</p> <p>4. During an interview on 8-27-14 at 1305 hours, the safety officer A5 confirmed that the safety committee had failed to follow its safety management plan and had conducted only one meeting since 8-01-13.</p>				