

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150168	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/01/2012
NAME OF PROVIDER OR SUPPLIER THE ORTHOPAEDIC HOSPITAL OF LUTHERAN HEALTH NETW			STREET ADDRESS, CITY, STATE, ZIP CODE 7952 W JEFFERSON BLVD FT WAYNE, IN 46804		
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 011479</p> <p>Survey Date: 10-30-12 to 11-01-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/09/12</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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S0102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on policy and procedure review, nurse aide personnel file review, and staff interview, the human resources director failed to implement the facility policy related to the state required home health aide registry check for 2 of 2 PCAs (patient care assistants) hired in 2012. (This is a repeat citation)</p> <p>Findings:</p> <p>1. at 1:30 PM on 11/1/12, review of the policy and procedure "Employee Recruiting and Retention", policy number A.2 with an effective date of 7/1/2010, indicated:</p> <p>a. on page 4 under section "9.0 Employee Background Checks...Abuse Registry Check (Certified Nurses' Aides). All candidates for CNA positions must be checked against the state's Abuse Registry for any prior sanctions prior to making an offer of employment..."</p> <p>2. at 10:05 AM on 11/1/12, review of personnel records indicated:</p> <p>a. staff member P1 was a PCA hired 5/7/12 who lacked documentation of</p>	S0102	<p>The Director of Human Resources reviewed with staff members findings from the ISDH survey of 10/30/12 to 11/1/12 related to documentation of new hire background check requirements for patient care assistants (PCA's) on 11/16/12. PCA's P1 and P2 background checks were completed and no issues of concern were noted. All PCA associates hired in 2012 were reviewed and re-verified on 11/16/12. The new hire PCA checklist was revised to add a checkbox for Abuse Registry background check prior to offer of employment on 12/6/12. Quarterly audits shall be conducted by the HR department on all new hires for appropriate documentation for the abuse registry check and reported to Quality. On-going.</p>	12/06/2012	

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	<p>having had the state's nurse aide registry checked prior to hire</p> <p>b. staff member P3 was a PCA hired 5/9/12 who lacked documentation of having had the state's nurse aide registry checked prior to hire</p> <p>3. at 11:00 AM on 11/1/12, interview with staff member #57, the director of human resources, indicated:</p> <p>a. both P1 and P3 are lacking any indication of a check of the states nurse aide registry at the time of hire, as required by facility policy</p> <p>4. at 12:10 PM on 11/1/12, interview with staff member #58, human resources, indicated:</p> <p>a. PCAs are not required to be CNAs, but are required to have the state's nurse aide registry checked for possible precious sanctions</p> <p>b. new staff member in human resources has been assigned to this facility's personnel records</p> <p>c. it was thought that the new staff member had been instructed to check the state's nurse registry for newly hired PCAs</p>			

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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 document review and interview, the facility failed to ensure that its policies/procedures were reviewed at least every three years.</p> <p>Findings:</p> <p>1. During an interview on 10-30-12 at 1250 hours, staff A2 indicated that the hospital policy/procedures were maintained in an electronic format and that the review process was documented separately. Staff A1 and A2 were requested to provide evidence of periodic updates and review for all nursing policy/procedures and none was provided prior to exit.</p> <p>2. During an interview on 11-01-12 at 0915 hours, staff A20 confirmed that no documentation was available to validate</p>	S0322	The Chief Nursing Officer will compile all nursing policies by 12/1/12. A tracking calendar will be initiated and maintained for all nursing and administrative policies to ensure appropriate triennial review by 1/1/13. The Chief Nursing Officer/Chief Executive Officer will oversee the review and revision, if applicable, of all nursing and administrative policies by 2/1/13.	02/01/2013			

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	<p>that the nursing policy/procedures had been updated and reviewed within the past three years. Staff A20 confirmed that the electronic policy/procedures for nursing failed to indicate a review by a responsible person and/or committee with the date of review.</p> <p>3. Review of the administrative policy/procedures Code Red-Fire Plan (approved 3-09), Medical Equipment-Risk Level Evaluation (approved 3-09), Licensing Process (approved 3-09) and Mandatory Inservice Program (approved 3-09) failed to indicate that a review had been performed within the past 3 years.</p> <p>4. During an interview on 11-01-12 at 1010 hours, staff A1 confirmed that the administrative policy/procedures had not been reviewed within the past 3 years.</p>			

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S0332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</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>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and interview, the hospital failed to require and failed to document competency validation of contracted housekeeping personnel for Operating Room (OR) cleaning and disinfecting for 4 of 4 contracted housekeeping personnel files reviewed.</p> <p>Findings:</p> <p>1. The policy/procedures Surgery Housekeeping (revised 5-10), Procedure for OR Room Cleaning (revised 7-10) and Cleaning OR--Contract Cleaning (reviewed 1-12) failed to ensure that housekeeping personnel files contain documentation of competency for cleaning the surgical and patient care areas as required by State law and as indicated by the Association of</p>	S0332	<p>The Nursing Director of OR will revise and update policies on "OR Room Cleaning" (2.21), "Surgery Housekeeping" (300.06), and "Cleaning OR-Contract Cleaning" to ensure competency validation requirements are included for environmental cleaning of the OR and patient care services. An orientation checklist will be developed for initial hire training. Completed by 12/17/12. Education will be provided to all of the nursing and contracted cleaning staff on environmental cleaning of the OR. Completed by 1/1/13. A competency validation will be completed quarterly on all contracted cleaning staff by the Director of OR and copies will be maintained in the employee files. Completed by 1/31/13 and on-going.</p>	01/31/2013

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	<p>PeriOperative Registered Nurses (AORN) 2007 Recommended Practices for Environmental Cleaning in the Perioperative Setting.</p> <p>2. On 10-30-12 at 1100 hours, staff A1 and A2 was requested to provide documentation of competency for 4 contracted housekeeping staff providing services at the hospital and one off-site location and none was provided prior to exit.</p> <p>3. During an interview on 11-01-12 at 1030 hours, staff A2 confirmed that the policy/procedures failed to ensure that contracted housekeeping personnel received competency validation on proper environmental cleaning and disinfection methods according to specific criteria for cleaning the OR Rooms.</p> <p>4. During an interview on 11-01-12 at 1100 hours, staff A24 confirmed that the personnel files lacked documentation of competency validation.</p>			

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S0394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 13 contracted services.</p> <p>Findings:</p> <p>1. On 10-30-12 at 1500 hours, a list of all contracted services was received from staff A2. The list of services failed to indicate a service provider for air exchange testing, biohazardous waste, elevators, 3 fire services, generator maintenance, hospital beds, medical records consultant, medical transcription, pest control, medical physicists and radiology equipment.</p> <p>2. Review of facility documentation indicated the following: air exchange testing by CS1, biohazardous waste disposal by CS2, elevator service by CS3,</p>	S0394	The Chief Financial Officer (CFO) reviewed the list of contracted services. Completed on 11/30/12. The CFO will ensure that air exchange testing, biohazardous waste disposal, elevator service, fire service providers including fire panel monitoring, generator service, hospital bed service, medical record consulting by medical transcription, pest control service, medical physicist calibration and inspection and radiology equipment service will be added to the list of contracted services inclusive of the scope and nature of the service. Completed by 12/31/12. An annual evaluation on each service will be completed and reviewed by the Medical Executive Committee. Review will be completed by 3/31/13.	12/31/2012			

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	<p>fire service providers included CS4 and CS5 and fire panel monitoring by CS6, generator service by CS7, hospital bed service by CS8, medical records consulting by CS9, medical transcription by CS10, pest control by CS11, medical physicist calibration and inspection by CS12 and radiology equipment service by CS13.</p> <p>3. On 11-01-12 at 1400 hours, staff A20 confirmed the list of contracted services failed to include the indicated service providers.</p>			

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S0418	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2)</p> <p>(b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action shall be documented.</p> <p>(2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.</p> <p>Based on document review and interview, the hospital failed to follow its policy/procedure and ensure that a surgical error event was reported to the quality assessment/performance improvement program and addressed by the program for a wrong-site surgery.</p> <p>Findings:</p> <p>1. The Orthopaedic Hospital Performance Improvement Plan (approved 2-12) indicated the following: " The Medical Executive Committee is responsible for ...coordination of performance improvement activities and analyzing their effectiveness in performance improvement ...High priority is given to high-volume, high-risk or problem-prone processes ...A root cause</p>	S0418	The Chief Quality Officer completed the root cause analysis and presented the results to the Medical Executive Committee on November 6, 2012 and to the Governing Board on November 14, 2012. The Chief Quality Officer reported the event to the Indiana State Adverse Event Reporting System on November 13, 2012. The Chief Quality Officer will track all reportable events to assure that they are reported within the 15 day required reporting period.	11/09/2012			

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	<p>analysis is conducted in the event of the following ...Surgery on the wrong patient or the wrong body part ... "</p> <p>2. An occurrence report dates 6-28-12 indicated that a wrong site surgery was performed on that date and indicated that the risk manager had reviewed and signed the document 7-03-12. On 10-31-12 at 1400 hours, the director of quality (staff A20) was requested to provide all related documentation regarding the occurrence report and subsequent investigation and none was provided prior to exit.</p> <p>3. During an interview on 10-31-12 at 1415 hours, staff A20 indicated that they had received the occurrence report from the risk manager. Staff A20 indicated that an investigation had been completed and confirmed that no report of the investigation was available after 4 months. Staff A20 indicated that the report had not been written up. Staff A20 confirmed that the occurrence had not been submitted to the Quality/Medical Executive Committee for review and action as a program priority and confirmed that the event had not been reported to the Indiana State Department of Health.</p> <p>4. During an interview on 11-01-12 at 1250 hours, the chief medical officer</p>			

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	indicated they were under the impression that the event had been reported to the state. The chief medical officer indicated they had not received an explanation from the Director of Quality in response to a request to submit the event to the Quality/Medical Executive Committee for review.			

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S0422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved; or any other information.</p> <p>(2) A potential reportable event may be</p>			

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	<p>identified by a hospital that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p>			

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	<p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2) Based on policy and procedure review, other document review, and staff interview, the facility failed to ensure that its process worked properly in failing to report an adverse event to the State within the time frame required by facility policy.</p> <p>Findings:</p> <p>1. at 2:05 PM on 10/31/12, review of the policy and procedure "Indiana State Department of Health - Serious Adverse Reporting", policy ("File") number GNO1.14, with a date of 03/01/09, indicated:</p> <p>a. on page 3 under section 4. "Reporting Requirements", it reads: "(A) The Chief Quality Officer shall submit a report to the Indiana State Department of Health as soon as reasonably and practicably possible, but no later than fifteen (15) days after the serious adverse event is determined to have occurred."</p> <p>2. at 2:30 PM on 10/30/12, review of risk/event reports for the last 6 months, indicated one report pertained to a patient on 6/28/12 who had a wrong site surgery performed (left knee arthroscopy to be done, right knee was operated on)</p> <p>3. interview with staff member #53, the</p>	S0422	The Chief Quality Officer reviewed the policy regarding the reporting of adverse events to the Stat November 2, 2012. The event was reported to the Medical Executive Committee on November 6, 2012 and the Governing Board on November 14, 2012. The adverse event was reported to the State on November 13, 2012. All future events will be reported as per Hospital policy and Indiana licensure regulations.	11/14/2012			

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	<p>CQO (Chief Quality Officer), at 2:15 PM on 10/31/12, indicated:</p> <ul style="list-style-type: none"> a. the risk form was signed off on 7/3/12 by a previous staff member (#55-Risk Manager) b. the facility policy indicates that a report to the state will be submitted, related to an adverse event, within 15 days of the determination that it occurred-Staff #55's initials on the risk form indicate that date was 7/3/12 c. staff member #55 had the authority to determine that an adverse event had occurred, their initials on the form confirm that determination d. an investigation was done, but the "written report" has not been completed since staff member #55 is no longer employed here and there has been a delay of 4 months e. a report related to the adverse event has not been presented to the medical staff and governing board (board of trustees here) as yet f. even though the written report of the investigation was not completed, the facility CQO could have submitted the information regarding the adverse event to the state within the 15 days of 7/3/12, as per facility policy, but failed to do so <p>4. interview at 12:55 PM on 11/1/12, with staff member #56, the chief medical officer, indicated:</p>			

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	<p>a. this staff member "knew as soon as I was told of the incident that it was reportable"</p> <p>b. this staff member was under the impression that this had been reported to the state, as required</p> <p>c. this staff member has been asking that this event be reported to the medical staff and does not know why there has been a delay regarding this</p>			

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S0592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on observation, document review and interview, the infection control committee failed to ensure that sanitary conditions were created in two sub sterile surgical ante rooms and one janitor closet in the pre operative area of the facility, failed to ensure the availability of the ICRA (infection control risk assessment) related to the lobby reconstruction project at the HOPD (hospital out patient department) failed to ensure that the contracted housekeeping services were provided in a safe and effective manner for its operating room (OR) suites and for one off-site outpatient surgery department.</p> <p>Findings: 1. at 10:35 AM on 10/31/12, while</p>	S0592	The Nursing Directors of all patient care areas will develop a routine cleaning schedule for the blanket warmers in the OR and patient care areas. Completed 11/30/12. The Nursing Director of OR will provide education to the contracted cleaning service regarding expectations of routine maintenance and cleaning of the environmental carts and equipment. Completed 11/21/12. The Nursing Director's of OR for inpatient and outpatient services will update the policy and procedure on "Cleaning of the OR" to include standardized process for terminal cleaning of the OR (sequential cleaning from contaminated to least contaminated). The policy will be reviewed through the Infection Control Committee. Completed by	01/31/2013			

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	<p>touring the sub sterile ante room out side surgical suites 26 and 27 in the company of staff members #50, the chief nursing officer, and #54, the surgical director/manager, it was observed that there was a build up of dust in the top cabinet of the Amsco Steris blanket warmer between the lower shelf (plenum) and the bottom of the upper cabinet</p> <p>2. at 11:05 AM on 10/31/12, while touring the sub sterile ante room out side surgical suites 24 and 25 in the company of staff members #50, the chief nursing officer, and #54, the surgical director/manager, it was observed that there was a build up of dust in the top cabinet of the Amsco Steris blanket warmer between the lower shelf (plenum) and the bottom of the upper cabinet</p> <p>3. at 11:35 AM on 10/31/12, while touring the pre operative are of the facility in the company of staff members #50, the chief nursing officer, and #54, the surgical director/manager, it was observed inside the janitor's closet that:</p> <ul style="list-style-type: none"> a. the janitor cart was grossly dirty with dust and debris b. the water hose used for filling the mop bucket was down and dangling in the dump sink making it possible for bacteria to grow in the hose if the drain would back up into the dump sink, thus 		<p>12/17/12. Education will be provided to all of the nursing and contracted cleaning staff on environmental cleaning of the OR. Completed by 1/1/13. The Nursing Director of OR and Infection Control will conduct quarterly environment of care rounds to ensure staff compliance and results will be reported to the Patient Safety Committee.</p> <p>Completed by 1/31/13. The Safety Officer and the Infection Control Practitioner will ensure the ICRA is completed prior to any construction on the hospital premises. The Safety Officer will maintain all documents in the official construction binder.</p> <p>On-going.</p>	

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	<p>contaminating the water hose</p> <p>4. interview with staff members #50 and #54 during the touring of the surgery areas of the facility indicated:</p> <ul style="list-style-type: none"> a. the blanket warmers are not currently on a cleaning schedule b. the dust found in the blanket warmers could be an infection control issue c. the contracted cleaning staff person has been instructed previously to keep the water hose out of the dump sink d. it was not known until now, that the janitor's cart was excessively dirty <p>5. interview with staff member #60, the infection control officer/practitioner, at 1:15 PM on 10/31/12, indicated:</p> <ul style="list-style-type: none"> a. an ICRA was done prior to the lobby construction/re modeling going on now at the out patient surgery building across the street b. the ICRA was signed off by both this staff member and a member of the facility management/properties staff (director of physical plant support services) c. it cannot be determined what the infection risks to surgical patients might be at the out patient surgery building as the ICRA cannot be found by any staff at the facility <p>6. The policy/procedures Cleaning OR-Contract Cleaning (reviewed 1-12),</p>			

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	<p>Procedure for OR Room Cleaning (revised 7-10) and the Outpatient Surgery policy/procedure Surgery Housekeeping (revised 5-10) failed to indicate an organized process (sequential cleaning from high to low and least contaminated to most contaminated) when describing the process for terminal cleaning of the OR suites and failed to indicate that they had been reviewed by the IC Committee.</p> <p>7. During an interview on 10-31-12 at 1445 hours, staff A1 confirmed that the policy/procedures failed to indicate a specific process for surgery suite cleaning to prevent contamination of previously disinfected surfaces by contracted housekeeping personnel.</p> <p>8. During an interview on 10-31-12 at 1500 hours, staff A1 confirmed that the documentation titled On Campus OR Checklist for staff P37 dated 10-26-12 and the documentation titled Day Porter-1st Floor Surgery Cleaning Procedures for staff P39 dated 10-19-12 failed to indicate that the performance of OR cleaning tasks was organized from high to low and least contaminated to most contaminated to reduce the potential for contamination of previously-cleaned surfaces.</p> <p>9. During an interview on 11-01-12 at</p>						

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	<p>1030 hours, staff A2 confirmed that the OR cleaning policy/procedures failed to indicate that the Infection Control Committee had reviewed and approved the policy/procedures.</p> <p>10. During an interview on 11-01-12 at 1100 hours, staff A24 confirmed that the contracted housekeeping personnel files lacked documentation indicating that the IC Committee-approved policy/procedures for OR cleaning and disinfection were provided and/or readily available to housekeeping staff.</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. Based on policy and procedure review, personnel health file review, and staff interview, the infection control practitioner failed to implement an effective employee health program by failing to monitor the employee health program in relation to newly hired staff for communicable disease history and TB (tuberculosis) testing for 2 RNs (registered nurses) hired in July 2012 (staff members P12 and P14).</p> <p>Findings: 1. at 12:45 PM on 11/1/12, review of the policy and procedure "Health Services for Associates", administrative policy number HR06.16, with a last revised date of</p>	S0606	The Director of Health Services reviewed with staff the findings from the ISDH survey of 10/30/12 to 11/1/12 related to mandatory healthcare screening (TB, communicable diseases) and employee follow up. Completed 11/2/12. P12 and P14 staff members' screenings were completed and employee files were updated. Completed 12/14/12. The Director of Health Services has developed and implemented a revised process for accurate and timely employee tracking. Completed 11/2/12. A quarterly audit of new employee files will be conducted by Health Services to ensure compliance and reported to Quality. On-going.	12/14/2012

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	<p>March 2011, indicated:</p> <p>a. under "Purpose/Procedure" on page one, in section "I. Post-Offer Employment Physical Examinations...Each examination will consist of a health history, a physical examination by Health Services provider, laboratory tests such as rubella/rubeola/mumps screen, drug screen, varicella screen for those without documentation of 2 varicella vaccines or positive antibody titer..."</p> <p>2. at 1:00 PM on 11/1/12, review of the "Tuberculin Skin Testing (TST) 2012 Plan (no policy number), with a date of approval by the Infection Control Committee on 11/30/11, indicated:</p> <p>a. CDC Guidelines recommend screening frequency for the low risk classification: 1. Baseline two-step TST (tuberculin skin test) or IGRA (Interferon Gamma Release Assay) for all HCW's (health care workers) upon hire.."</p> <p>3. review of personnel files at 10:05 AM on 11/1/12, indicated:</p> <p>a. staff RN P12 was hired 7/30/12 and:</p> <p>A. was lacking documentation in the personnel file related to the history of having had the disease (authenticated by a practitioner), an immune titer, or documentation of having had 2 injections for Varicella</p>			

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	<p>B. had a copy of a note sent 10/31/12 to the staff member indicating the staff member needed a "Chicken Pox Blood Draw" by 11/12/12</p> <p>b. staff RN P14 was hired 7/23/12 and:</p> <p>A. was lacking documentation of a second TB test (2nd step) as required for newly hired staff</p> <p>B. had a copy of a note in the personnel file that was sent to the employee indicating the need for the "2nd Step" for "TB Skin Test" due buy 11/12/12 and sent on 10/31/12</p> <p>4. interview with staff member #61, RN with employee health services, at 12:30 PM on 11/1/12 indicated:</p> <p>a. per the protocol of employee health services, staff member P14 should have had the 2nd TB test, of the 2 step process, done 10 days after the July 2012 first TB test was read</p> <p>b. it is unclear how the lack of Varicella documentation/information allowed staff member P12 to begin work before this information was in the employee's file</p> <p>c. follow up for staff member P12 and P14 should have occurred prior to 10/31/12, which was 3 months after hire.</p> <p>d. it would help the employee health services if it was mandatory to have all of the health documentation completed prior to a new employee beginning work--there is no leverage to get the employee to</p>			

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	return to the health services once they have already started work			

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S0608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on policy and procedure review, observation, and staff interview, the infection control practitioner failed to implement facility policy related to dress code for two staff observed.</p> <p>Findings: 1. at 9:00 AM on 10/31/12, review of the policy and procedure "Operating Room (OR) Dress Code", with a policy number of PR41.006 and a date issued of December 2010, indicated: a. under section "II. Purpose/Procedure", it reads: "...4) Hair: A) All hair will be covered with an appropriate disposable surgical hat...7) Masks and Eye Shields:...D) Masks will NOT be left dangling around the neck..."</p>	S0608	The Nursing Director of OR reviewed "Operating Dress Code" Policy (PR41.006) with all nursing, ancillary and physician staff. Completed 12/7/12. The Nursing Director of OR will conduct quarterly observation rounds to ensure compliance with the policy. On-going.	12/07/2012			

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	<p>2. While touring the OR department at 10:40 AM on 10/31/12 in the company of staff members #50, the chief nursing officer, and #54, the OR director/manager, it was observed in room #26 that the anesthesiologist caring for the surgical patient had hair below the skull cap (which rested/ended just above the ears) that was not covered (about 3 inches of thick black hair not covered)</p> <p>3. at 10:40 AM on 10/31/12, interview with staff member #54 indicated the anesthesiologist should have had all hair covered, as per facility policy</p> <p>4. at 4:10 PM on 10/31/12, in the company of staff members #50 and #54, it was observed in the main hospital hallway (outside the administration offices) that one staff member in surgical scrubs was walking down the corridor with a surgical mask down and dangling about the neck</p> <p>5. interview with staff member #54 at 4:10 PM on 10/31/12 indicated:</p> <ul style="list-style-type: none"> a. masks are not to be worn dangling about the neck b. it was thought that this was a contracted radiology staff person, but that this was still not per facility policy 			

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S0744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on policy and procedure review, medical staff rules and regulations review, patient medical record review, and staff interview, the facility failed to ensure legibility and completeness of medical records for 3 of 8 patient records (pts. #2, #4 and #8).</p> <p>Findings:</p> <p>1. at 12:40 PM on 10/30/12, review of the policy and procedure "Medical Record Access and Documentation Guidelines", Policy number PR10.012, with a date issued of February 2011, indicated:</p> <p>a. on page one under "1.0 Policy Statement", it reads: "Complete and accurate medical record documentation shall be developed and maintained..."</p> <p>b. on page 5 under section "3.0 Procedure", it reads: "...3.13...Legible handwriting...Error corrections done in a manner that does not obliterate original entry;..."</p> <p>2. at 1:20 PM on 10/30/12, review of the Medical Staff Rules and Regs dated 11/1/11, indicated:</p>	S0744	<p>The Chief Nursing Officer and Quality Manager reviewed with all nursing and physician staff the documentation guidelines as outlined in the "Medical Record Access and Documentation Guidelines" Policy (PR 10.012). Completed 12/14/12.A quarterly medical record audit will be performed by the contracted service provider to ensure compliance of accurate completion of the medical record and will be reported to the Medical Executive Committee. On-going.</p>	12/14/2012

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NAME OF PROVIDER OR SUPPLIER THE ORTHOPAEDIC HOSPITAL OF LUTHERAN HEALTH NETW				STREET ADDRESS, CITY, STATE, ZIP CODE 7952 W JEFFERSON BLVD FT WAYNE, IN 46804			
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	<p>a. under "Article II Medical Records" on page 5, it reads: "2.1 Preparation/Completion of Medical Records...The Attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient..."</p> <p>3. review of patient medical records at 12:15 PM on 10/31/12 and 1:45 PM on 11/1/12, indicated:</p> <p>a. pt. #2 had write overs on the date and time of the orders written 10/18/12</p> <p>b. pt. #4 had write overs on the "H & P Handwritten" form with R (right) changed to L (left) 8 times on the pre operative history and physical form completed 9/4/12.</p> <p>c. pt. #8 had:</p> <p>A. write overs by the physician on dates and times of orders on 10/1/12 and 10/8/12</p> <p>B. an incomplete "Transfer Form" in the medical record</p> <p>4. at 4:15 PM on 10/31/12 and 3:15 PM on 11/1/12, interview with staff member #50, the chief nursing officer, indicated:</p> <p>a. facility policy regarding legibility was not implemented for patients #2, #4 and #8 as listed above</p> <p>b. the Transfer Form for pt. #8 was not completed--only had the physician's signature present</p>						

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S0812	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(4)(A)(B)(C)(D)(E)(F)(G)(H)(I)(J)(K)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(4) Maintain a file for each member of the medical staff that includes, but is not limited to, the following:</p> <p>(A) A completed, signed application. (B) The date and year of completion all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A copy of the member's current Indiana license showing the date of licensure and current number or an available certified list provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the medical licensing board. (D) A copy of the member's current Indiana controlled substance registration showing the number, as applicable. (E) A copy of the member's current Drug Enforcement Agency registration showing the number, as applicable (F) Documentation of experience in the practice of medicine.</p>						

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	<p>(G) Documentation of specialty board certification, as applicable.</p> <p>(H) Category of medical staff appointment and delineation of privileges approved.</p> <p>(I) A signed statement to abide by the rules of the hospital.</p> <p>(J) Documentation of current health status as established by hospital and medical staff policy and procedure and federal and state requirements.</p> <p>(K) Other items specified by the hospital and medical staff.</p> <p>Based on documentation review and interview, the facility failed to maintain its credentialed medical staff files regarding the current health status for Mycobacterium Tuberculosis (Tb) for 9 of 12 credential files reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure Infection Control Plan 2012 (approved 2-12) indicated the following: " The infection control program will operate under those standards set forth by ... the Centers for Disease Control (CDC) ... "</p> <p>2. The Centers for Disease Control and Prevention (CDC) <u>Fact Sheets: Tuberculosis: General Information</u>. July 2007 indicated the following: " The [PPD] skin test reaction should be read between 48 and 72 hours after administration. A patient who does not</p>	S0812	<p>Findings from the ISDH survey of 10/30/12 to 11/1/12 related to lack of documentation of the timing of administration or reading of the TB skin test in credentialed medical staff records were reviewed with the staff members responsible for credentialing by the Quality Manager. Completed 12/7/12. The TB skin test form will be revised to include the time of administration and reading . Completed by 1/14/13. A quarterly audit will be conducted by the medical credentialing staff to ensure compliance and will be reported to the Medical Executive Committee. On-going.</p>	01/14/2013

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	<p>return within 72 hours will need to be rescheduled for another skin test. "</p> <p>2. Documentation of tuberculin (Tb) skin testing for 9 credentialed medical staff (MD# 40, 41, 42, 43, 44, 45, 46, 49, 50 and 51) failed to indicate a time of administration or time of test reading in the credential files provided for review.</p> <p>3. During an interview on 10-31-12 at 1625 hours, staff A21 confirmed that the documentation failed to indicate times for administration or skin test reading in accordance with the CDC guidelines.</p>			

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S0870	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.</p> <p>Based on the review of medical staff rules and regulations, patient medical record review, and staff interview, the medical staff failed to ensure the implementation of their rules and regs specific to physician orders for 6 of 8 patients (pts. #1, #2, #3, #4, #7, and #8).</p> <p>Findings: 1. at 1:20 PM on 10/30/12, review of the Medical Staff Rules and Regs dated 11/1/11, indicated: a. under "Article III General Conduct of Care" on page 9, it reads in section "3.2 Written/ Verbal/Telephone Treatment Orders...Orders for treatment shall be in writing, dated, timed and authenticated..."</p>	S0870	The Quality Manager reviewed with physician staff its findings from the ISDH survey of 10/30/12 to 11/1/12 related to documentation of the medical record, ie. dating and timing of orders. Completed on 12/6/12. A quarterly medical record audit will be performed by the contracted service provider to ensure compliance of accurate completion of the medical record. This is included in the physician quality report card and reported to the Medical Executive Committee. On-going.	12/06/2012	

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	<p>2. at 4:15 PM on 10/30/12, 12:15 PM on 10/31/12, and 1:45 PM on 11/1/12, review of patient medical records indicated:</p> <p>a. pt. #1:</p> <p>A. lacked an order for the transfusion of 2 units of blood product</p> <p>B. lacked a time with the physician's authentication of standing physician's orders of 10/22/12</p> <p>b. pt. #2:</p> <p>A. lacked a date and time with the physician's authentication of standing physician's orders of 10/18/12</p> <p>c. pt. #3:</p> <p>A. lacked a date and time with the physician's authentication of standing physician's orders of 9/25/12</p> <p>d. pt. #4:</p> <p>A. lacked a time with two separate written orders of 9/5/12</p> <p>e. pt. #7:</p> <p>A. lacked a date and time with the physician's authentication of standing orders on 8/7/12</p> <p>B. lacked a time with the physician's authentication of standing orders (two separate pages) of 8/7/12</p> <p>f. pt. #8:</p> <p>A. lacked a time of authentication on the Transfer Form dated 10/9/12</p> <p>B. lacked documentation by the physician of a time of written orders on 10/1/12, 10/3/12, 10/6/12, and 10/8/12</p>						

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	<p>C. lacked a time with the physician's authentication of standing physician's orders on 10/6/12</p> <p>3. at 4:15 PM on 10/31/12 and 3:15 PM on 11/1/12, interview with staff member #50, the chief nursing officer, indicated:</p> <p>a. dates and times of authentication of orders was not per medical staff rules and regulations as stated/written in 2. above</p> <p>b. standing orders have a specific space for a date and time of authentication by physicians that has not been completed in either the date section, the time section, or both sections for pt. records #1, #2, #3, #7, and #8</p>			

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S0871	<p>410 IAC 15-1.5-5 Medical Staff 410 IAC 15-1.5-5(b)(3)(O)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual receiving a verbal order shall date, time, and sign the verbal order in accordance with hospital policy. Authentication of a verbal order must occur within forty-eight (48) hours unless a read back and verify process described under items (i) and (ii) is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge.</p> <p>(i) As an alternative, hospital policy may provide for a read back and verify process for verbal orders. Any read back and verify process must require that the individual receiving the order shall immediately read back the order to the ordering physician or other responsible individual who shall immediately verify that the read back order is correct.</p> <p>(ii) The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. Where the read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge.</p>			

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	<p>Based on policy and procedure review, medical staff rules and regulations review, patient medical record review, and staff interview, the facility failed to ensure that policies related to verbal and telephone orders were implemented for 3 of 8 patients (pts. # 3, #4, and #5). (This is a repeat deficiency)</p> <p>Findings:</p> <p>1. at 12:40 PM on 10/30/12, review of the policy and procedure "Verbal/Telephone Orders", policy number PR10.005, date issued February 2011, indicated:</p> <p>a. under "Purpose/Procedure", it reads: "...4. The receiver of the order will write down the complete order verbatim, then read it back and receive confirmation from the M.D. who gave the order. 5. Verbal/Telephone orders must include date and time order is written...7. All verbal/telephone orders must be read and verified with the ordering physician. Verbal/Telephone orders will be documented as V.O.R &V/ or T.O.R.&V/Dr/nurse. This means verbal (V) or telephone (T) order read (R) and verified (V) with the physician giving the order..."</p> <p>2. at 1:20 PM on 10/30/12, review of the Medical Staff Rules and Regs dated 11/1/11, indicated:</p>	S0871	<p>The Quality Manager reviewed with the Nursing Directors the findings from the ISDH survey of 10/30/12 to 11/1/12 related to the lack of documentation and following the standard verbal order and read back process. Completed on 12/7/12.</p> <p>The Nursing Directors reviewed with the nursing staff the findings of the ISDH survey regarding the verbal order process and policy. Completed by 12/17/12.</p> <p>A quarterly medical record audit will be performed by the contracted service provider to ensure compliance of accurate completion of the medical record and the verbal order standard process. This is reported to the Medical Executive Committee and the Patient Safety Committee.</p> <p>On-going.</p>	12/17/2012			

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	<p>a. under "Article III General Conduct of Care" on page 9, it reads in section "3.2 Written/ Verbal/Telephone Treatment Orders...All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order back to the physician and indicate that the individual has confirmed the order..."</p> <p>3. at 12:15 PM on 10/31/12, review of patient medical records indicated:</p> <p>a. pt. #3 had verbal or telephone orders written by nursing at 2300 hours on 9/23/12; at 0310 hours on 9/24/12; and at 1150 hours on 9/24/12 that lacked the identification of whether these were verbal or telephone orders and lacked the repeat and verified notation</p> <p>b. pt. #4 had:</p> <p>A. an order page titled "Physician Order" that lacked a date and time of the written order; lacked the notation by nursing staff that this was either a verbal or telephone order; lacked the read back and verified notation; and lacked nursing signature and name of the physician giving the order</p> <p>B. a telephone order on 9/5/12 by</p>			

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	<p>nursing that lacked the repeat/verified notation</p> <p>c. pt. #5 had:</p> <p>A. a "P.O." (telephone order) on 10/28/12 at 0800 hours that lacked a repeat/verified notation by nursing staff</p> <p>B. an order written by nursing staff that lacked information as to whether this was a verbal or telephone order; lacked the repeat and verification notation; and lacked a time of the order on 10/25/12</p> <p>4. at 4:15 PM on 10/31/12 and 3:15 PM on 11/1/12, interview with staff member #50, the chief nursing officer, indicated:</p> <p>a. the orders written by nursing staff for patients #3, #4 and #5, as listed in 3. above, lacked the indication as to whether these were verbal or telephone orders, lacked the repeat and verification notation, and/or lacked the time of the order</p> <p>b. nursing staff are not following the verbal and telephone order policy</p>			

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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, patient medical record review for those transferred to another facility, Nova StatsStrip glucometer control solution and test strip package insert review,</p>	S0912	The Chief Nursing Officer will revise and update the nursing policy "Accu-Check Inform Whole Blood Glucose Monitoring System" (2.27) to include manufacturer's recommendations	12/31/2012			

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	<p>observation, and staff interview, the CNO (chief nursing officer) failed to ensure nursing staff implemented the transfer policy for 2 of 4 patients, pts. # 2 and 8; failed to procure a physician order before transfusing blood to one patient, #1; and failed to follow the facility policy or the manufacturer's recommendation related to glucometer control solutions and monitor strips in two nursing stations.</p> <p>Findings:</p> <p>1. at 2:00 PM on 10/31/12, review of the transfer policy titled "Transfer of a Patient", policy number EP11.02, with a date issued of February 2011, indicated:</p> <p>a. under section "II. Procedure", it reads: "...B. Non-Emergency or Emergency Transfers Requiring Care Outside of the Services Offered By the Orthopedic Hospital...2...The physician and RN (registered nurse) will complete the Transfer Form that will accompany the patient to the Emergency Department..."</p> <p>2. at 2:00 PM on 10/31/12, review of the policy "Transferring Patient to Another Facility", policy number PR20.014, with a revised date of May 2011, indicated:</p> <p>a. under section "II. Necessary Equipment", it reads: "...D. Patient Transfer Summary form..."</p> <p>b. under section "III. Procedure", it reads: "...I. Complete transfer form</p>		<p>regarding expirations of strip vials and solutions. Completed by 12/17/12. The Patient Safety Rounding Team will audit to assure that expiration dates are marked on vials and within the appropriate dating period. Audit results will be reported to the Patient Safety Committee. Revised Policy 2.27 (noted above), in conjunction with policies "Transfer of A Patient" (EP 11.02) and "Transferring Patient To Another Facility" (PR 20.014), will be reviewed by all nursing staff. Completed by 12/31/12. A quarterly audit will be performed by the Nursing Directors to ensure compliance with expected transfer standards. This will be reported to the Patient Safety Committee. On-going. Failure to obtain a physician order for blood administration as indicated in a medical record review was addressed with the staff involved. Completed 11/30/12. An educational competency was completed by all nursing staff regarding the expected standards of the policy "Administration of Blood Products" (PR 20.010). Completed 11/30/12. A quarterly audit shall be performed by laboratory services on blood administration and will be reported to the Medical Executive Committee and the Patient Safety Committee. On-going.</p>		

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	<p>following directions in Procedure, General Patient Care, Admit-Transfer-Dismiss, 'Inter-Agency Transfer Forms.'"</p> <p>3. at 9:30 AM on 10/31/12 and 1:45 PM on 11/1/12, review of patient medical records indicated:</p> <p>a. pt. #2 was admitted on 10/17/12 (admitted to the floor at 10:45 PM on 10/17/12, pt. chart label reads 10/18/12 admission) and transferred to the telemetry unit of the host hospital after the rapid response team was called, and lacked a transfer form in the medical record</p> <p>b. pt. #8 was admitted on 9/30/12, transferred on 10/9/12 and lacked completion of the transfer form in the patient's record (authenticated by the physician, but incomplete document)</p> <p>4. at 2:05 PM on 10/31/12, interview with staff member #51, the quality resource manager, indicated:</p> <p>a. a transfer from for pt. #2 could not be found by either nursing staff or medical records personnel</p> <p>5. at 3:15 PM on 11/1/12, interview with staff member #50, the chief nursing officer, indicated:</p> <p>a. the transfer form for pt. #8 was not completed by nursing personnel as</p>						

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	<p>required by facility policy</p> <p>6. at 2:05 PM on 10/31/12, review of the policy and procedure "Administration of Blood Products", policy number PR20.010, with a revised date of June 2011, indicated:</p> <p>a. under section "IV. Procedure", it reads: "A. Verify physician order..."</p> <p>7. at 4:15 PM on 10/30/12, review of patient medical record #1 indicated:</p> <p>a. nursing documented at 10:39 AM on 10/24/12 that "yes" the "MD order confirm" was completed</p> <p>b. the patient received 2 units of blood on 10/24/12</p> <p>c. the chart lacked a physician order to transfuse blood</p> <p>8. at 3:15 PM on 11/1/12, interview with staff member #50, the chief nursing officer, indicated:</p> <p>a. there are orders for pt. #1 for "T& S" (type and screen) and to "crossmatch", but no order to transfuse</p> <p>b. it is unclear why nursing staff documented confirming the physician order for transfusion when none could be found in either the hand written physician orders, or the CPOE (computerized physician order entry) [on line computer orders] for the patient</p>			

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	<p>9. at 3:30 PM on 11/1/12, review of the manufacturer's package insert "Nova StatStrip Glucose Control Solution", indicated:</p> <p>a. under "Precautions", it reads: "...When you open a new vial of control solution, count forward 3 months and write that date on the label of the control solution vial..."</p> <p>10. at 3:30 PM on 11/1/12, review of the manufacturer's package insert "Nova StatStrp Glucose Test Strips", indicated:</p> <p>a. under "Expiration", it reads: "The expiration date is printed on the vial of test strips. Once opened, the StatStrip Test Strips are stable when stored as indicated for up to 180 days..."</p> <p>11. at 3:30 PM on 11/1/12, review of the nursing policy and procedure "Accu-Chek Inform Whole Blood Glucose Monitoring System", policy number 2.27 with a last revised date of January 2011, indicated:</p> <p>a. on page 2 under section "IV. Equipment and Materials", it reads: "...C. Reagent Storage Requirements: 1...Strips are stable until the manufacturer's expiration date printed on the vial...2...Solutions are stable for 90 days after opening..."</p> <p>12. at 3:30 PM on 10/31/12 while on tour of the nursing station 1A and 1B in the</p>						

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	<p>company of staff members #50, the chief nursing officer, and #59, the quality manager, it was observed that:</p> <p>a. one bottle of glucometer strips was dated as opened on 10/25/12, but had a smudged/smearred discard date written by nursing staff on the vial</p> <p>b. one bottle of glucometer strips was present in the testing kit had no date opened and no date of expiration written on the vial by nursing staff when put into place/service making it impossible to know when the 180 days for expiration was accomplished</p> <p>13. at 3:45 PM on 10/31/12 while on tour of the nursing station 2A and 2B in the company of staff members #50, the chief nursing officer, and #59, the quality manager, it was observed that:</p> <p>a. two control solution vials that were dated as opened on 7/3/12 and lacked an expiration date written on either vial</p> <p>b. one bottle of strips with an opened date written of 10/5/12 and and expiration date written by nursing as 1/5/13 on the vial</p> <p>14. interview with staff members #50 and #59 at 3:50 PM on 10/31/12 indicated:</p> <p>a. the bottle/vial of strips found at nursing station 1A and 1B must be discarded as it cannot be determined when they were opened and when the 180</p>			

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	<p>days of expiration after opening would occur (see 12. b. above)</p> <p>b. both of the control solutions found at nursing station 2A and 2B, expired 10/3/12 and lacked the notation on the vials of an expiration date at the time of opening (see 13. a. above)</p> <p>c. the strip bottle/vial found at the nursing station 2A and 2B was incorrectly marked with an expiration date of 1/5/13--that would be 90 days after opening and the strips are good for 180 days after opening (see 13. b. above)</p> <p>d. the facility policy does not reflect manufacturer's recommendations as the policy indicates strips are good until the expiration of the date on the strip vial--rather than 180 days after opening</p> <p>e. nursing staff is not dating vials of control solutions and strips when opening with both the date opened and the date of expiration, (or correct dates of expiration as with the strip bottle)</p>			

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S1197	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</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>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the facility failed to ensure that periodic fire inspections were performed in 2011 and 2012.</p> <p>Findings:</p> <p>1. On 10-30-12 at 1045 hours, staff A1 and A2 was requested to provide documentation of the most recent fire inspections and none was provided prior to exit.</p> <p>2. During an interview on 10-31-12 at 1545 hours, the safety officer staff A7 confirmed that the facility failed to ensure that a fire inspection was performed in 2011 or 2012 by State or local officials. Staff A7 confirmed that no documentation requesting an inspection from fire officials was available for review.</p>	S1197	The Director of the Environment of Care contacted the Fire Marshall and a fire inspection was completed by the State Fire Marshall, C. Bosselman on 11/26/12. A tracking record has been developed by the Director of the Environment of Care to ensure fire inspections are completed annually as required. Completed 12/6/12.	12/06/2012

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S1714	<p>410 IAC 15-1.6-4 OUT-PATIENT CARE SERVICES 410 IAC 15-1.6-5(c)(1)(2)(3)</p> <p>(c) Outpatient care services may include, but are not limited to, the following:</p> <p>(1) Observation care.</p> <p>(2) Ambulatory care.</p> <p>(3) Other care programs designated by the hospital.</p> <p>Based on policy and procedure review, out patient surgery medical record review, and staff interview, the facility failed to ensure that 1 of 2 patients received discharge instructions, as per facility policy for pt. # 7.</p> <p>Findings:</p> <p>1. at 3:30 PM on 11/1/12, review of the policy and procedure "Discharge Criteria From Acute/PAC (post anesthesia care) and Subacute", Policy # PR43.003, with a "Date Issued" of October 2011, indicated:</p> <p>a. under "Purpose", in section 2., it reads: "...i. Written and verbal discharge instructions for care will be given including emergency procedures. Patients and responsible adults must verbalize understanding of the instructions."</p> <p>2. review of two out patient surgery patient medical records at 1:45 PM on 11/1/12 indicated:</p>	S1714	The nursing policy "Discharge Criteria From Acute/PAC (post anesthesia care) and Subacute" (PR 43.003) that indicates all patients will receive written and verbal discharge instructions was reviewed with all nursing staff. Completed on 11/13/12. A quarterly medical record audit and patient interview will be completed by the Nursing Director to ensure on going compliance with completion of discharge instructions. On-going.	11/13/2012	

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	<p>a. pt. #7 lacked a copy of discharge instructions in the medical record</p> <p>3. interview with staff member #50, the chief nursing officer, at 3:15 PM on 11/1/12 indicated:</p> <p>a. a thorough search of the on line medical record indicate that no discharge instructions for pt. #7 could be found</p> <p>b. facility policy requires nursing staff to give both oral and written discharge instructions to surgical patients</p>			