

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150129	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/13/2011
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005110</p> <p>Survey Date: 10-11/13-11</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 11/02/11</p>	S000000		
S000310	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(C)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the</p>			

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>following:</p> <p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(C) Ensuring that all health care workers, including contract and agency personnel, for whom a license, registration, or certification is required, maintain current license, registration, or certification and keep documentation of same so that it can be made available within a reasonable period of time.</p> <p>Based on document review and interview, the hospital failed to follow its policy to maintain a current certification for health care workers for whom a certification is required for 1 of 16 personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the job description of a Certified Surgical Technologist (CST) indicated one of the requirements was CST certification. 2. Review of 16 personnel files indicated file PF#12 was that of a Certified Surgical Technologist. Further review of that file indicated it lacked current certification documentation. 3. On 10-13-11 at 2:20 pm, employee #A2 was requested to provide 	S000310	The current job description for a Certified Surgical Technologist (CST) has been revised to state that certification is preferred, not required. This revision is the responsibility of the surgery manager and is effective as of 12/2/2011. All job descriptions for the surgery department are the responsibility of the surgery manager.	12/02/2011			

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S000406	<p>documentation of the above-stated employee's current CST certification. The requested employee, upon interview, indicated there was no documentation available and no documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review, the hospital failed to include 3 services provided by a contractor and failed to report the outcome of monitoring 1 contracted service as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QA&I program indicated it did not include the contracted services of biohazardous</p>	S000406	The contracted services of biohazardous waste, contract nursing and tissue transplant have been added to QA&I program report. In addition, the outcome of monitoring the blood bank service has also been added. The first report will be at the QA meeting of November 15, 2011, however it will exclude data for tissue, which is new data collected and will be reported as 4th quarter 2011. The manager of each area is responsible to provide their report to the QA Manager who is then responsible	11/15/2011

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S000554	<p>waste, contract nursing and tissue transplant. It also did not include the reporting of outcome of monitoring blood bank service.</p> <p>2. On 10-13-11 at 10:15 am, employee #A2 upon interview, indicated there was no documentation as indicated above and no documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients in the Surgery Department for 1 Janitor's Closet.</p> <p>Findings include:</p> <p>1. During the facility tour of the Surgery Department on 10-12-11 at 0955 hours in the Janitor's Closet a Neptune device for disposing of body fluids from surgery</p>			S000554	<p>for presentation of these report(s) to the QA Committee. Each manager has been educated as to the documentation required.</p> <p>The Neptune devise for disposing of body fluids from surgery will remain in the current location observed on 10/12/11. The room has become a "dirty" room and all other clean supplies have been moved to a clean area. These supplies were moved on 11/14/11 to a clean room in the surgery department. The surgery manger, who is ultimately responsible, educated the staff related to this issue, and the "Neptune Room" is now a "dirty" room as of 11/14/11.</p>		11/14/2011

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S000952	<p>was installed.</p> <p>2. On 10-12-11 at 0955 hours staff #44 confirmed that this was the Janitor's Closet that staff use to prepare cleaning solutions to clean the operating rooms and staff dispose of body fluids from surgery via the Neptune device in the Janitor's Closet.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy review, transfusion record review, and staff interview the facility failed to follow approved medical staff policies for the administration of blood transfusions for six of seven transfusion records reviewed.</p> <p>Findings included:</p> <p>1. On 10/12/11 between 10:00 a.m. and 12:00 p.m. review of a policy titled "Blood: STARTING BLOOD FOR</p>	S000952	The policy titled "Blood: STARTING BLOOD FOR TRANSFUSION, EFFECTIVE: 05-77, revised: 02-09, has been revised on 11/11/11 to state "assess patient status and obtain vital signs every 30 minutes during the transfusion and immediately after transfusion is complete". This change in policy reflects AABB standards and current practice. The Nursing educator will reinforce this practice through blood	12/15/2011

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S001118	<p>TRANSFUSION, EFFECTIVE: 05-77, REVISED: 02-09" revealed: "PROCEDURE N. Assess patient status and obtain vital signs (blood pressure, pulse, and respirations) every thirty minutes during the transfusion and one hour after completion of transfusion." 2. Transfusion record review revealed: Transfusion records C#1, C#3, C#4, C#5, C#6, and C#7 had the post vitals performed at the completion of the transfusion, not the one hour after completion of the transfusion as required by the approved policy. 3. In interview on 10/12/11 between 10:00 a.m. and 12:00 p.m., staff member C#5 acknowledged the approved policy for transfusion administration has not been followed for six of seven transfusion records reviewed.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p>		competency training which will be completed by 12/15/11. A QA monitor will be put in place for the first two quarters of 2012 to measure the compliance of the documentation as defined in policy. The Chief Nursing Officer is ultimately responsible to assure practice.	

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	<p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 3 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 10-11-11 at 11:15 am in the presence of employee #A4, it was observed in the Stress Lab, there was an alcohol hand-based sanitizer dispenser (ABHS) on the wall directly over an electric radio. On 10-11-11 at 11:35 am in the presence of employee #A4, it was observed in the Radiology Control Room, there was an ABHS on the wall directly directly over an electrical socket. In both of the above cases, the location relative directly over an ignition source, posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source. On 10-11-11 at 1:35 pm in the presence of employee #A4, it was observed in the Maintenance & 	S001118	<p>Regarding findings 1, 2 and 3: On October 14, 2011, the manager of Plant Services completed a hospitalwide, room-by-room inspection to identify incorrect locations of hand sanitizers. All hand sanitizers that were located too close to an ignition source, were relocated to an appropriate location. (See attached photos).The staff in these areas were educated on appropriate locations for hand sanitizers by the Plant Services Manager, who is ultimately responsible.Regarding finding 4: On October 11, 2011, the manager of Plant Services secured the fire extinguisher located on a workbench unsecured at time of survey. The manager of Plant Services, who is ultimately responsible, also educated the maintenance staff as to the importance of making sure that all pressure cylinders are secured at all times.</p>	10/14/2011

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S001150	<p>Engineering area there was 1 fire extinguisher on a workbench unsecured by chain or holder.</p> <p>5. If the fire extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the facility failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code for 4 of 4 dialysis machines.</p> <p>Findings include;</p>	S001150	<p>On November 11, 2011 new backflow prevention devises were installed on all four dialysis machines (see attached photo and work order). The manager of Plant Services, who is ultimately responsible, educated the dialysis staff regarding the importance of not removing these devises.</p>	11/14/2011			

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S001164	<p>1. During the facility tour of the Dialysis Room on 10-12-11 at 1150 hours, 4 dialysis machines were observed to be connected with hoses to water spigots without backflow prevention devices.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on document review, the hospital failed to provide evidence of preventive maintenance (PM) for 6 pieces of equipment.</p> <p>Findings:</p> <p>1. On 10-11-11 at 11:20 am, employee #A4 was requested to provide documentation of PM on a TEE Probe and a Stryker Care patient stretcher located in the Echo Cardio Room.</p> <p>2. On 10-11-11 at 2:45 pm, employee</p>	S001164	Finding 1: The manager of Plant Services contacted TriMedx on November 10, 2011 to have them come in and complete the required preventive maintenance on the Echo Cardio Equipment, including TEE probe and Stryker Care patient stretcher. On November 14, 2011, the manager of Plant Services, who is ultimately responsible for this requirement, educated the Echo Cardio staff about the importance of making sure all PM's are completed. The PM's were completed by TriMedx on November 14, 2011 (see attached PM Report).Regarding	11/14/2011

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	<p>#A4 was requested to provide documentation of PM on a stair step device, hand exercise device, Hudson UBE-BD exerciser and wall pulley, all located in the Inpatient Physical Therapy area.</p> <p>3. Review of documents entitled Westview ARC Cleaning Schedule Month/Year October 2011 and one entitled Monthly PM - Please indicated exact date of check, both indicated the activities for the wall pulley were only for cleaning, not preventive maintenance (checking the condition and effectiveness of all parts).</p> <p>4. No further documentation of PM for all the above-stated items was provided prior to exit.</p>		<p>Findings 2 and 3: A Preventive Maintenance schedule has been initiated for non-electrical equipment used in the Physical Therapy area. Non-electrical equipment will be checked and documented monthly by the PT staff (see attached). The PT manager, who is ultimately responsible for this requirement, has educated the PT staff.</p>		