

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150097	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
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NAME OF PROVIDER OR SUPPLIER  MAJOR HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 150 W WASHINGTON ST SHELBYVILLE, IN 46176
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005086</p> <p>Survey Date: 1-14/16-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Linda Dubak, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 01/18/13</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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S0604	<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 exposed to communicable diseases. Based on record review and staff interview, the hospital failed to monitor the immune status for four of four kitchen health care workers reviewed for the five food transmissible diseases to minimize the risk of secondary spread of infection.</p> <p>Findings: 1. On 1-14-13, between 12:00 p.m. and 2:00 p.m., record review of infection control and employee health policy/procedures indicated a history of the five food transmissible diseases had not been obtained for Staff Persons # 1 through # 4. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment</p>	S0604	Food and Nutrition Services Policy and Procedure: Reporting of Employee Illness was updated to include a three part questionnaire about the five foodborne illnesses and their related diseases on January 15, 2013. The current food service employees read and signed off on this between January 14 and January 24, 2013. This deficiency will be prevented in the future by the Director of Food and Nutrition Services reviewing this policy with all new hires and a signed copy being sent to Human Resources. Food Service employees will also receive annual review of the foodborne illnesses utilizing Performance Manager. Compliance with this deficiency	01/24/2013			

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	<p>shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), f the food employee or applicant:</p> <p>(1) is diagnosed with an illness due to:</p> <p>(A) Salmonella spp.;</p> <p>(B) Shigella spp.;</p> <p>(C) Shiga toxin-producing Escherichia Coli;</p> <p>(D) Hepatitis A virus; or</p> <p>(E) Norovirus "</p> <p>2. Staff Person # 8 acknowledged, on day of survey at 2:00 p.m. that kitchen health workers had not been monitored for the five food transmissible diseases.</p>		<p>will be reported will be reported on the Food and Nutrition quarterly departmental quality report. Person Responsible: Director Food and Nutrition Services</p>	

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to administer blood in accordance with approved medical staff policies and procedures for five of seven transfusions reviewed.</p> <p>Findings included: 1. Policy/procedure review on 1/15/13 between 10:00 a.m. and 12:00 p.m. found a policy/procedure titled: "ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS Revised 7/12" which stated: "PROCEDURE: 5. Obtain a baseline set of vital signs for each unit to be used in later comparison. 11. Fifteen minutes after blood has reached the patient vital signs are repeated and charted in TAR (transfusion administration record). 12.5 Obtain another set of vital signs one hour after completion of unit of blood and record in transfusion record."</p>	S0952	<p>In order to ensure that vital signs are taken at the appropriate intervals and documented appropriately, nursing services has created a worksheet. This worksheet includes the appropriate times to obtain vital signs. This worksheet may be used to document vital signs while blood is infusing and then the VS can be entered into the electronic record. Prevention of recurrence: All blood products will be checked for appropriate vital signs times, any errors will require a followup conversation by management with the nurse that administered the blood. Blood Bank QA will be reported on quarterly nursing departmental quality reports with the expectation of 100% accuracy. Person Responsible: Director of Nursing</p>	02/01/2013			

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	<p>2. a. Transfusion #1 had the 15 minute vitals taken at 25 minutes after the start of the transfusion, not 15 minutes per procedure.</p> <p>b. Transfusion #2 had the pre vitals taken at the same time as the transfusion was started which is not possible and would not indicate whether the patient was normal to start the infusion. Also the transfusion was finished at 2100 and the 1 hour vitals were done at 2112 which is not 1 hour post.</p> <p>c. Transfusion #4 was finished at 1620 and the 1 hour post vitals were done at 1830 which is 2 hours and 10 minutes past the policy/procedure requirement.</p> <p>d. Transfusion #5 had the transfusion starting at 0425 and had the 15 minute vitals done at 0414 which is before the transfusion started.</p> <p>e. Transfusion #7 started at 1330 and had the 15 minute vitals taken at 1352 which is 22 minutes past policy/procedure requirement.</p> <p>3. In interview on day of survey, staff person #36 acknowledged the above mentioned transfusions were documented as described and indicated problems with the electronic records were noted and were being monitored and assessed to obtain results to follow policy/procedure. 2012 data supplied indicate of 744 units of blood products given 105 were discrepant.</p>			

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, 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"> <li>On 1-14-13 at 10:40 am in the presence of employees #A4, #A6 and #A8, it was observed in the engineering department, there was 1 fire extinguisher on the floor unsecured by chain or holder.</li> <li>If the above extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</li> <li>On 1-14-13 at 11:35 am in the presence of employees #A4, #A6 and #A8, it was observed in the Nuclear Medicine room, there was an</li> </ol>	S1118	<p>The fire extinguisher referred to in (2.) was taken out of service on January 16, 2013. This was a demo fire extinguisher and demo fire extinguishers are no longer be allowed at Major Hospital. The hand sanitizer referred to in (3.) was moved from being directly over an electrical rheo switch on January 16, 2013. The hand sanitizer referred to in (4.) was moved from being directly over an electrical outlet on January 21, 2013. Long term prevention: A policy about hand sanitizer placement was written and put into place on January 28, 2013 and reviewed with all Engineering Staff. Demo fire extinguishers are no longer allowed at Major Hospital. This will be monitored on safety rounds and deficiencies reported to Safety Committee on at least a quarterly basis. Person Responsible: Engineering Manager</p>	01/28/2013			

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	<p>alcohol-based hand sanitizer (ABHS) on the wall directly over an electrical rheostat switch.</p> <p>4. On 1-14-13 at 1:25 pm in the presence of employees #A4, #A6 and #A8, it was observed in the Massage Therapy room, there was an ABHS on the wall directly over an electrical outlet.</p> <p>5. In both of the above instances (#3 and #4) of the alcohol-based hand sanitizers, their direct position above an ignition source posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source.</p>			

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation and interview, the facility failed to provide evidence of preventive maintenance (PM) for 3 pieces of equipment.</p> <p>Findings:</p> <p>1. On 1-14-13 at 1:25 pm, in the presence of employees #A4, #A6 and #A8, it was observed in the Massage Therapy room there was an exam table. Employee #A4 was requested to provide documentation of PM on this piece of equipment.</p> <p>2. On 1-14-13 at 1:40 pm, in the presence of employees #A4, #A6 and #A8, it was observed in the Radiation Therapy Room there was a blanket warmer. Employee #A4 was requested to provide documentation of PM on this piece of equipment.</p>	S1164	The three pieces of equipment that were cited in 1, 2 & 3 were logged into the hospital PM program and initial PMs were completed on January 16, 2013. To prevent this deficiency from happening in the future the new Medical Oncology and Radiation Oncology managers were instructed to always notify Engineering staff when bringing new equipment into the building. This occurred on January 16, 2013. Person Responsible: Engineering Manager	01/16/2013			

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	<p>3. On 1-14-13 at 2:00 pm, in the presence of employees #A4, #A6 and #A8, it was observed in the SportsWorks gym there was a Detecto weight scale. Employee #A4 was requested to provide documentation of PM on this piece of equipment.</p> <p>4. In interview, on 1-16-13 at 1:45 pm, employee #A8 indicated there was no current PM on any of the above 3 pieces of equipment and no further documentation was provided prior to exit.</p>			

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S1186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with their policy.</p> <p>Findings:</p> <p>1. Review of a document entitled CODE ORANGE - FIRE PLAN, section FIRE DRILL PROCEDURE, approved 1-31-12, indicated we [the facility] are required to hold MONTHLY fire drills.</p> <p>2. Review of fire drills conducted at the</p>	S1186	The Code Red - Fire Plan for Non Main Campus was updated to state that fire drills at these locations are required on a quarterly basis on January 29, 2013. Our current processes will keep us compliant with fire drills at our offsite locations. Safety Committee will monitor offsite fire drill frequency at least quarterly. Person Responsible: Engineering Manager	01/29/2013			

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	<p>hospital's 4 offsites for year 2012, indicated the following</p> <p>SportsWorks/reNovo Orthopaedic Center - fire drills conducted in July and October Benesse Oncology Center - fire drills conducted in January and April UnaVie Cardiology Center - fire drills conducted in January, April, July and October The Sleep Center of Major Hospital - fire drills conducted in January, April, July and October</p> <p>3. In interview, at 10:00 am on 1-16-13, employee #A4 confirmed the above and no further documentation was provided prior to exit.</p>				