STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151304	A. BUILDING 00 B. WING	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RUSH MEMORIAL HOSPITAL	1300 N MAIN ST RUSHVILLE, IN 46173

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S 0000 Bldg. 00	This visit was for a State Licensure survey. Facility Number: 005082 Survey Dates: 10/18/2021 - 10/20/2021 QA: 10/25/21	S 0000		
S 0596 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (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: (iii) Cleaning, disinfection, and sterilization. Based on document review, observation and interview, the facility failed to ensure proper endoscope reprocessing on 1 of 6 scopes. Findings Include: 1. Review of policy titled: Endoscope Reprocessing Procedures (POL 19.4.1611.1)	S 0596	Surgery Director will review endoscope procedure POL 19.4.1611.1 with staff to confirm endoscopes are to be reprocessed when scope not used in 5 days. Staff will check daily for any outdated scopes and log that they have checked for the outdates. An	11/05/2021

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

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	indicated if scope is not used in 5 days, reprocess. 2. Tour of Surgery on 10/20/21 at approximately 10:40 am with S-6 (Director of Surgery), this surveyor observed an endoscope in the scope storage cabinet labeled, #2808016 cleaned on 10/11/21, which made the last processing 9 days prior. 3. Interview on 10/20/21 at 10:45 am with S-6 confirmed that scope was #2808016 cleaned on 10/11/21, which made the last processing 9 days prior.		audit by the surgery director will be performed once a month for compliance from the medivator digital log. This will be done via log. Add Scope cleaning to netlearning for yearly review to all surgery staff.	
S 0664 Bldg. 00	410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(b) (b) The hospital shall assure that all laboratory services provided to its inpatients and outpatients are performed in a facility possessing a valid certificate, in accordance with 42 CFR Part 493 (excluding Subparts F, R, Q, and T) authorizing the performance of testing in the specialty or subspecialty of service for level of complexity in which the test is categorized. Based on document review and interview, Laboratory failed to provide standard of care in use of their blood glucose testing equipment in 3 of 3 areas approved for point of care glucose testing. Findings Include: 1. Review of policy titled: Point of Care Testing (702) indicated that the Emergency, Medical/Surgical and Surgery departments were	S 0664	Lab Director will be switching to the Abbott Freestyle Precision Pro Glucose Meters. The Abbott Freestyle Precision Pro Glucose Meters are for professional use. CNO, Lab Director and IT Director are meeting with the company to get the meters interfaced with our EMR. The process will take up to 90 days to complete. Lab Director will be responsible for maintaining	01/28/2022

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	approved to provide point of care glucose testing; program follows manufacturer's instructions. 2. Review of Contour Next blood glucose user's manual indicated that blood glucose meter was for individual use only. 3. Interview on 10/19/21 at 2:03 pm with S-7 (Director of Laboratory) confirmed that the Contour Next blood glucose meter was for individual use; not multi-patient.		compliance and education on the new meters.	
S 1022 Bldg. 00	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. Based on document review, observation and interview, the pharmacy failed to ensure monitoring of 1 of 1 fluid warming cabinets (Surgery). Findings Include: 1. Review of policy titled: Pharmacy Equipment - Refrigerators and Freezers (730.203) created 05/25/2020, indicated that pharmacy is responsible for monitoring the temperature of refrigerators and freezers throughout the campus. 2. On tour of Surgery at 10:15 am on 10/20/21 with	S 1022	Pharmacy Director ordered temperature probe to be added to the warming cabinet. Policy and Procedure updated to reflect the warming cabinet as a monitored device. Pharmacy Director will do an audit twice a month to ensure the monitoring reports are accurate and monitoring appropriately. The company we use is Log In (sensoscientific.com)	12/03/2021

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	S-6 (Director of Surgery), this surveyor observed a warming cabinet with no temperature readings; upon opening the door there were 2-1000 milliliter bags of fluid and the air felt warm on surveyor's hand. 3. Interview on 10/20/21 at 10:15 am with S-6 confirmed lack of temperature readings or equipment to read the temperature in/on warming cabinet. 4. Interview on 10/20/21 at 11:25 am with S-9 (Director of Pharmacy) confirmed that pharmacy had not been checking the temperature of the warmer cabinet and that it was pharmacy's responsibility and should be treated like the Refrigerator and Freezers policy.			
S 1024 Bldg. 00	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction. Based on document review, observation and interview, the facility failed to ensure removal of outdated medications in 1 of 3 crash carts	S 1024	Pharmacy and Surgery Director will re -educate both surgery and	11/26/2021

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	(Surgery). Findings Include: 1. Review of policy titled: Expired or Defective Medications (730.225), created 08/04/21, indicated that expired medication will be removed from saleable inventory 3 months prior to expiration. 2. Tour of Surgery area on 10/20/21 at approximately 10:20 am with S-6 (Director of Surgery), this surveyor observed 2 Lidocaine injectables 2%, 100 milligrams/5 milliliters with an expiration date of 9/21. 3. Interview with S-6 on 10/20/21 at approximately 10:20 am confirmed that 2 Lidocaine injectables 2%, 100 milligrams/5 milliliters had an expiration date of 9/21.		pharmacy team on the expired medication policy. Pharmacy and Surgery Director will do monthly audits to assure medications are being checked for outdates by the pharmacy and surgery team. Director will hold staff accountable and follow disciplinary process if policy and process are not followed.	
S 2136 Bldg. 00	410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8 (c)(7) (c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows: (7) An operative report describing techniques, findings, and tissue removed or altered shall be written or dictated immediately following surgery and authenticated by the surgeon. Based on document review and interview, the medical staff failed to provide an immediate post-operative note in 2 of 8 surgery patients reviewed (Patients 6 and 8)	S 2136	1. Surgery Director reviewed with all surgeons expectations for operative notes in surgeon's monthly meeting. Surgery Director	11/04/2021

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	Findings Include: 1. Review of Medical Staff Rules and Regulations, last reviewed in 2021, indicated "Operative reports should be dictated or written immediately after surgery and entered in the EMR as soon as possible". 2. Review of Patient 6's medical record indicated surgery on 04/27/21 (day shift) and lacked documentation of immediate post operative note; dictated post operative note dated 04/28/21. 3. Review of Patient 8's medical record indicated surgery on 06/16/21 (day shift) and lacked documentation of immediate post operative note; dictated post operative note dated 06/17/21. 4. Interview on 10/19/21 at 11:00 am with S-6 (Director of Surgery) confirmed that Patient 6 and 8's medical record lacked documentation of an immediate post operative note and had a dictated post operative note dated the day after surgery.		reviewed the HIM policy and make sure all policies match and reflect that the operative note must be performed by the end of the day. Surgery Director will perform random chart audits once a month to ensure compliance. Surgeons will be informed by Surgery Director of any non- compliance of the policy. Disciplinary process will be followed based on policy.	