STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150176	A. BUILDING 00 B. WING	08/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTUCKIANA MEDICAL CENTER LLC	4601 MEDICAL PLAZA WAY CLARKSVILLE, IN 47129

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S 0000 Bldg. 00	This visit was for a State licensure survey of a hospital. Facility Number: 011788 Dates: 8/29/16 to 8/30/16 QA: 11/28/16 jlh	S 0000		
S 0102 Bldg. 00	410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a) (a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on document review the facility failed to comply with all applicable state laws for 2 of 8 employee files reviewed. Findings include: 1. Review of IC 16-28-13-4, reads in Sec. 4. (a): Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or (2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a healthcare facility; shall apply within	S 0102	S102 410 IAC 15-1.2-1 COMPLIANCE WITH RULES (1-3) Criminal background checks will be performed on each new employee and a copy placed in the employees file. All Dietary personnel's records have been reviewed and background checks have been completed including the delinquent records found on the inspection. Director Human Resources assumed his positon as of April 10, 2015. All newly hired staff members from that date forward has had their records reviewed and	12/31/2016

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

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	three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. 2. Review of employee files indicated that a criminal history background check was not available for review for employees # 5 and #6 (unlicensed dietary staff). 3. On 8/30/16 at 1:50 p.m., staff member #5 (Human Resources) acknowledged the above-listed missing documentation.		all back ground checks have been verified to be in the records. Prior to close of business December 31, 2016, all current staff records will be reviewed and any needing background checks will be completed. Responsible Party: Director, Human Resources will ensure completion of background checks for each employee upon hiring. The Director, Human Resources will ensure completed background checks are placed in each employee's file. The Chief Operating Officer will sign off on each background investigation for all employees upon completion. The Compliance Officer will be responsible to monitor the overall compliance of this standard moving forward. Completion Date: 12/31/2016	
S 0308 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (c) The governing board is responsible for managing the hospital. The governing board shall do the following:			

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	(6) Require that the chief executive officer develops policies and programs for the following: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on document review and interview, the chief executive officer (CEO) failed to ensure orientation of applicable hospital, department, service and personnel policies per their policy and procedure (P&P) for 3 of 3 contracted staff (P1, P4 and P7) and 2 of 5 hospital employees (N14 and N15). Findings: 1. Policy HR 2.01 New Employee Orientation Program, revised/reapproved on 3/31/2015 indicated: A. all new employees of the Hospital will receive a general orientation to the hospital and a specific orientation to their department and position. . B. the individual department manager's will be responsible for coordinating a new employee orientation in their departments. C. a checklist will be completed as each process is reviewed. The Executive Secretary will be responsible for following-up on incomplete items. The checklist is placed in the personnel file	S 0308	S308 410 IAC 15-1.4-1 GOVERNING BOARD (1-5): The Human Resources department will maintain New Employee Orientation records for all employees to include contracted employees. The Human Resources department will also maintain a list of new employees and ensure compliance with attendance at New Employee Orientation before departmental orientation has ended. The Department Head of the new employee's department will ensure all new employees have completed departmental specific orientation and forward the documentation to Human Resources for filing in staff member's record. All contract employee's records have been reviewed and the members identified delinquent will have general hospital orientation completed and departmental orientation completed prior to Close of Business December 31, 2016. Attached is an example of the orientation being utilized for Surgical Services, Dietary, Plant Operations, Laboratory, etc.	12/31/2016

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	after all items have been completed. 2. Review of personnel files and documents for contracted staff P1 and P7 lacked evidence of general hospital, department and position orientation and those for P4 lacked evidence of orientation to the department or position. 3. On 8/30/16 at 10:00am, A5, Human Resources Director, indicated documentation of orientation to the hospital, department and position was not available for P1 and P7, nor was evidence of orientation to the department or position for P4. 4. Review of personnel files confirmed personnel: A. N14 (Surgical Technician) hired on 6/30/16 lacked documentation of completion of department specific orientation. B. N15 (Surgical Technician) hired on 5/5/16 lacked documentation of completion of department specific orientation. 5. Staff N3 (Human Resources Director) was interviewed on 8/30/16 at approximately 1300 hours and confirmed the above-mentioned hospital personnel lacked documentation of department specific orientation.		Responsible Party: Director, Human Resources Director will be responsible for compliance of this standard. The Compliance Officer will be responsible to monitor the overall compliance of this standard to ensure compliance. Completion Date: 12/31/2016	

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S 0312 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D) (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: (D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on document review and staff interview, the hospital's administration failed to document annual employee evaluations for two of eight personnel files. Findings included: 1. On 8/30/16 at 1:20 p.m., review of 2 (#'s P1 and P2) personnel files failed to	S 0312	**S312 410 IAC 15-1.4-(c) (6) (D) GOVERNING BOARD** (1-2): Department Managers/Directors will ensure annual employee evaluations are performed and provided to Human Resources for placement in the	12/31/2016

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	contain annual evaluations. 2. On 8/30/16 at 1:20 p.m., employee #5 (Human Resource Director) acknowledged the above-listed missing documentation.		employee's permanent file. The Human Resources department will maintain lists of employee evaluation due dates and Distribute to each department Manager/Director on a quarterly basis. Responsible Party: Department Managers/Directors are responsible for conducting employee evaluations in a timely manner and providing to Human Resources for placement in the employee's file. The Human Resources Director will be responsible for providing updated lists of employee evaluations that are due to Department Heads/Managers quarterly. All staff personnel files have been reviewed and the files delinquent for annual evaluations for 2016 have been identified and appropriate Department Heads have been notified and are required to have corrected documents to Director, Human Resources prior to Close of Business December 31, 2016. COO, CNO and CFO are responsible to ensure completion	

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			prior to December 31, 2016. The Compliance Officer will be responsible to monitor the overall compliance of this standard moving forward. Completion Date: 12/31/2016	
S 0330 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K) (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: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable. Based on record review and staff interview, the hospital's administration failed to document annual employee fire life safety training for eight of eight eligible personnel files.	S 0330	**S330 410 IAC 15-1.4-1 (c) (6) (K) GOVERNING BOARD**	12/31/2016

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	Findings included: 1. On 8/30/16 at 1:20 p.m., review of 8 (#'s P1 through P8) personnel files failed to contain annual fire life safety training. 2. On 8/30/16 at 1:20 p.m., employee #5 (Human Resources) acknowledged the above-listed missing documentation.		**(1-2):** All Employees will receive fire life safety training on an annual basis. Responsible Party: Director, Plant Operations will be responsible to ensure appropriate materials and testing for fire and life safety training is completed annually and appropriate documentation is provided to Human Resources for inclusion in staff members file. All contract employees files have been reviewed and all have received fire, safety training. Attached is the example of the training materials that is being utilized by Plant Operations for this annual training. Compliance Officer will be responsible to monitor the overall compliance of this standard moving forward. Completion Date: 12/31/2016.	
S 0408 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)			

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	(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: (2) All functions, including but not limited to the following: (A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i). Based on document review and interview, the quality assessment and performance improvement (QAPI) program failed to include the 2 functions of sterile processing and response to patient emergencies in its review and evaluations for the past 4 quarters. Findings: 1. Review of policy PI 1.01 titled Performance Improvement Plan indicated the following: a. Analysis of data is completed in order to identify and resolve any breakdowns that may result in sub-optimal patient care and safety. b. The primary goal of the Organizational PI (Performance	S 0408	**S408 410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT** **(1-3):** Beginning December 22, 2016, reports on sterile processing and evaluations for the functions of sterile processing will be presented quarterly at the Quality Assessment and Improvement Committee meetings. Beginning December 22, 2016, reports on patient emergencies will also be reported on a quarterly basis through the Quality Assessment and Improvement Committee. These reports will be forwarded to the MEC and Board of Directors via Quality Minutes presented at each of their respective meetings.	12/22/2016

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	Improvement) Plan is to continually and systematically plan, design, measure, assess and improve performance of Hospital wide key functions and processes relative to patient care. c. Date Last Updated: 09/30/2015 2. Review of 2015 and 2016 QAPI reports and meeting minutes lacked evidence of QAPI program review of sterile processing or response to patient emergencies for the past 4 quarters. 3. On 8/30/16 at 11:45am, A3, Chief Nursing Officer, indicated the QAPI program did not include review or evaluation for the functions of sterile processing and response to patient emergencies for the past 4 quarters.		Responsible Party: The OR Director will be responsible for reporting on sterile processing and functions of sterile processing each quarter. The CNO will be responsible for reporting on patient emergencies each quarter. Completion Date: 12/22/16	
S 0560 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(d) (d) A person qualified by training or experience shall be designated as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on document review and interview, the infection control nurse	S 0560	**S560: 410 IAC 15-1.5-2 INFECTION CONTROL**	12/31/2016

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	(ICN) failed to ensure ongoing annual implementation of the hospital's Infection Control Education policy for 7 of 8 personnel (P1, P2, P3, P5, P6, P7 and P8). Findings: 1. Review of policy IC 1.07 titled Infection Control Education indicated the following: a. Policy: A coordinated education plan for employees, contract or agency is in place in accordance with state and federal guidelines... b. Procedure: Departmental specific Infection Control education will take place, coordinated by the ICN and the Department Director. c. Annual education includes: Handwashing, Blood Borne Pathogens Exposure Control Plan, Tuberculosis Control Plan d. Date Last Updated: 09/30/2015 2. Review of personnel files for P1-P8 lacked evidence of annual infection control education (ICE) for P1, P2, P3, P5, P6, P7 and P8. 3. On 8/30/16 at 10:00am, A5, Human Resources Director, indicated that evidence of annual ICE was not available for P1, P2, P3, P5, P6, P7 or P8.		(1-3): Annual competencies will be completed for all hospital personnel on an ongoing basis. Annual competencies will include handwashing, blood borne pathogens exposure control plan, and TB plan. The Infection Control Competency sign-in sheet and general competency is attached. The Infection Control Nurse will be responsible for forwarding appropriate documentation to Human Resources for placing in staff member's record. Human Resources will be responsible to ensure documentation is placed in appropriate file. Responsible Party: The Infection Control Nurse will be responsible for ensuring annual competencies are completed for hospital personnel. CNO will monitor to ensure compliance with this standard. Completion Date: 12/31/2016	

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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 infection control committee (ICC) failed to ensure cleaning and disinfection procedures for use of 1 product (Cidex/Cidex test strips) were in accordance with manufacturer recommendations. Findings: 1. On 8/30/16 between 1:15pm and 2:15pm, during facility tour, in the presence of A3, Chief Nursing Officer, in the sterile processing room was a plastic container indicated to contain Cidex.	S 0596	**S596 410 IAC 15-1.2-2 INFECTION CONTROL** (1-4): The Cidex OPA Solutions Log Sheet has been revised to include required documentation for new test strip bottles, control testing prior to use of scopes, and weekly testing. A new Cidex Solution Log Sheet will be started for each new bottle of test strips. Cidex solution testing will also occur prior to use of scopes. The Cidex OPA Solution Log Sheets for Surgery and Echo/Ultrasound are attached. Education regarding the use of Cidex OPA solution was provided by Karen	12/01/2016

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	2. Review of the package insert for "Cidex OPA Solution Test Strips" indicated the following: It is recommended that the testing of positive and negative controls be performed on each newly opened test strip bottle of "Cidex OPA Solution Test Strips". After this initial testing, it is recommended that testing of freshly prepared positive and negative controls be performed on a regular basis as established by your own quality control procedures and program. 3. Review of documents titled "Cidex OPA Solutions Log Sheet" with test dates indicated to be between 5/20/16 to 8/30/16, indicated 3 different bottles of test strips were used during this time. The documents lacked documentation of positive and negative control testing of any test strips. 4. On 8/30/16 at 1:45pm, S1, RN, indicated Cidex test strips were not being checked for both positive and negative controls.		Flanders, the Advanced Sterilization Products (ASP) representative, on 10/12/2016. The Cidex OPA Solutions book given to the staff during the in-service will be kept in the OR area for reference. See attached in-service sign in sheet Responsible Party: The OR staff will be responsible for conducting and documenting new test strip and control testing. CNO will monitor to ensure compliance with this standard. Completion Date: 12/1/2016	
S 0606 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows:			

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	(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: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. **Based on document review and staff interview, the facility failed to document complete and document the immunization history for one of eight dietary employees.** **Findings include;** **1. The staff member personnel file (# 8) contained no documentation of immunization history for hepatitis B including whether this had been offered and whether or not this immunization had or had not been accepted.** **2. On 830/16 at 1:40 p.m., staff member # 5 acknowledged that the above-listed employee had incomplete documentation as listed above.**	S 0606	S606 410 IAC 15-1.5-2 INFECTION CONTROL (1-2): Immunization records reviewed during the ISDH visit will be reviewed for completeness. Missing immunizations and/or titers will be obtained for those employees. Beginning December 1, 2016, Immunization records will be obtained for each new employee and reviewed by both Human Resources and Infection Control Nurse. When the Infection Control Nurse is not available, the Chief Nursing Officer will review immunization records with Human Resources Director/designee. Employees who have been previously immunized will submit that documentation to Human Resources upon hire for review by Human Resources and the Infection Control Nurse and/or CNO. An employee who has missing	12/31/2016

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			immunization records or abnormal titers will be required to receive additional testing/immunizations per direction from the Infection Control Nurse and/or CNO. Review of immunizations and/or titers must be completed and additional testing/immunization process started before the employee begins working in a patient care area. Responsible Party: The Human Resource Director is responsible for obtaining new employee immunization records. The Human Resource Director and Infection Control Nurse are responsible for reviewing immunization records/titers and approving or requiring additional immunizations during the orientation period. The CNO and Compliance Officer will be responsible to ensure compliance with this standard. Completion date: 12/31/2016 and on-going	
S 0670 Bldg. 00	410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(d) (d) Laboratory supervisory and testing personnel qualifications shall be consistent with the work assignments			

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	150176	A. BUILDING 00 B. WING	08/30/2016

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	and in compliance with 42 CFR 493. Based on document review and interview, the hospital failed to ensure laboratory services were performed by qualified person(s) for 1 of 4 laboratory personnel. Findings include: 1. Review of 1 (#4) laboratory medical laboratory technician's (MLT) file indicated there was no documentation to either confirm this employee had graduated from an MLT school or passed the licensure program requirements for an MLT certificate prior to reporting laboratory results. 2. On 8/30/16 at 11:50 a.m. staff #5 (Human Resources) acknowledged the above listed employee file was missing the documentation listed above.	S 0670	**S670 410 IAC 15-1.5-3 LABORATORY SERVICES** **(1-2):** The Human Resources Director will obtain a copy of each licensed employee's credentials, either by verifying through an approved licensing website and/or by making a copy of the employees certificate/diploma. Responsible Party: The Human Resources Director is responsible for verifying any licensed employee's credentials and placing verification in the employees file before the employee begins departmental orientation. All current Laboratory staff have had credentials verified and appropriate documentation placed in their records. Compliance Officer will be responsible to ensure compliance with this standard. Completion Date: 12/1/2016	12/01/2016
S 0726	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES			

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Bldg. 00	410 IAC 15-1.5-4 (c)(7)(A)(B) (c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows: (7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following: (A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws. (B) A procedure that ensures that unauthorized individuals cannot gain access to patient records. Based on document review, observation and interview the facility failed to ensure the privacy and security of each patient's Protected Health Information (PHI) in 2 (Medical Surgical and Telemetry 3 Units) of 9 areas toured. Findings: 1. Policy 1.03, Protected Health Information (PHI) Privacy and Security, revised/reapproved 3/31/2015 indicated: A. Kentuckiana Medical Center (the "Provider") is committed to ensuring the privacy and security of each patient's Protected Health Information (PHI).	S 0726	**S726 410 IAC 15-1.5-4 MEDICAL RECORD SERVICES** (1-3) Employees will minimize and secure computer monitor screens when he/she is not entering data in the electronic medical record and/or are away from the computer. Responsible Party: Employees will be responsible for minimizing and securing the computer monitor screens when away from the computer or when not entering data. Department Managers will be responsible for ensure employees comply withthis standard.	09/30/2016

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	B. we will comply with all applicable laws and rules regarding patient privacy and security to insure the confidentiality and safety of our patients' medical records. 2. During tour of units Medical Surgical and Telemetry 3 on 8/29/16 at approximately 1200 and 1300 hours, accompanied by staff N1 (Chief Financial Officer), patient medical record information was visible on computer monitor screens in the public hallway. 3. Staff N1 was interviewed on 8/29/16 at approximately 1300 hours and confirmed patient medical record information was visible on computer monitor screens in public hallways on units Medical Surgical and Telemetry 3. Staff N1 confirmed clinical staff had not properly secured the patient medical record information prior to walking away from the computer monitor allowing for access of unauthorized persons and persons not involved with the patient's care.		CNO and COO will be responsible to monitor this standard to ensure compliance Completion Date: 9/30/2016	
S 0952 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved			

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	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 document review and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedures for eight of ten patients. Finding(s) include: 1. The policy, "Administration of Blood Products", Document # BB 5.41, updated 9/30/15, read: "An (sic) registered nurse (RN) will initiate the blood product transfusion, monitor the patient continuously for the first 15 minutes, and then if no problems are identified, periodically until the transfusion is completed. Document the date and time the transfusion ended on the Product Identification Tag." 2. In review of the documentation for eight patients, receiving fourteen blood units, complete documentation, per policy, on the Product Identification Tag form was incomplete including:	S 0952	S952 410 15-1.5-6 NURSING SERVICE (1-3): Each nurse hired prior to September 22, 2016 has received an electronic copy of the Bridge blood product administration presentation that was also given during New Employee Orientation for their reference. All new nurses will receive blood product administration training during Cerner class and orientation. Audits will be performed on all blood product administration records and 1:1 education provided when deficiencies are found. Repeated deficiencies in blood product administration documentation by specific staff members will result in written warning and could end in termination of employee if deficiencies are not corrected in the future. Responsible Party: The Nurse Educator and IT Clinical Manager will provide education regarding blood product administration and documentation. The lab manager will conduct blood product administration audits and report findings to the CNO, Educator, IT Clinical Manager, and Department	12/02/2016

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	Patient #1: --Unit 1a, was administered on 8/0916 at 8:50 p.m.: The unit's 15 minute vitals were documented at 9:03 p.m. (13 minutes, which was 2 minutes early). --Unit 1b, was administered on 8/0916 at 11:25 p.m.: The unit's 15 minute vitals were documented at 11:38 p.m. (13 minutes, which was 2 minutes early). Patient #3: --Unit 3a, was administered on 8/10/16 at 2:48 p.m.: The unit's 15 minute vitals were documented at 3:00 p.m. (8 minutes, which was 7 minutes early). --Unit 3b, was administered on 8//10/16 at 6:19 p.m.: The unit's 15 minute vitals were documented at 6:31 p.m. (12 minutes, which was 3 minutes early). Patient #4: --Unit 4a, was administered on 8/12/16 at 12:42 p.m.: The unit's 15 minute vitals were documented at 1:05 p.m. (23 minutes, which was 8 minutes late). --Unit 4b, was administered on 8/12/16 at 4:39 p.m.: The unit's 15 minute vitals were documented at 5:00 p.m. (21 minutes, which was 6		Directors. The Laboratory manager is task to provide minimally a weekly report to the CNO and COO of all documentation supporting compliance with this standard. The Laboratory manager will provide notification to the CNO and COO of any deviation from this standard within 24 hours of the occurrence. Completion Date: 12/02/2016	

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	minutes late). Patient #5: --Unit 5a, was administered on 8/06/16 at 2:04 p.m.: The unit's 15 minute vitals were documented at 2:21 p.m. (17 minutes, which was 2 minutes late). --Unit 5b, was administered on 8/06/16 at 4:20 p.m.: The unit's 15 minute vitals were documented at 4:44 p.m. (24 minutes, which was 9 minutes late). Patient #7: --Unit 7a, was administered on 7/14/16 at 3:18 p.m.: There was no documentation for the unit's end time. --Unit 7b, was administered on 7/14/16 at 10:50 p.m.: The unit's 15 minute vitals were documented at 10:55 p.m. (5 minutes, which **was** 10 minutes early). Patient #8: --Unit 8b, was administered on 7/11/16 at 4:57 p.m.: The unit's 15 minute vitals were documented at 5:14 p.m. (17 minutes, which was 2 minutes late). Patient #9: --Unit 9a, was administered on 7/03/16 at 11:# a.m.: The unit's			

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	15 minute vitals were documented at 12:00 p.m. (13 minutes, which was 2 minutes early). --Unit 9b, was administered on 703/16 at 3:01 p.m.: The unit's 15 minute vitals were documented at 3:09 p.m. (8 minutes, which was 7 minutes early). Patient #10: --Unit 10a, was administered on 5/09/16 at 8:12 a.m.: The unit's 15 minute vitals were documented at 8:21 a.m. (9 minutes, which was 6 minutes early). 3. On 8/30/16 at 10:20 a.m., staff member #10 (nurse witness) acknowledged that the fourteen above-listed patient blood units had incorrect or incomplete documentation, per the blood administration policy.			
S 1014 Bldg. 00	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c) (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling,			

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	storage, use, monitoring, and quality assurance of all drugs and biologicals. Based on document review, observation and interview, the facility failed to ensure staff followed their policy regarding safe storage of medications in 3 (Intensive Care Unit [ICU], Telemetry 1 and Telemetry 3) of 9 areas toured. Findings: 1. Policy 09-01, Medication Management - Storage, revised/reapproved 01/16 indicated: A. medications and devices shall be stored to ensure their integrity, stability and effectiveness. Medications and biologics will be stored so that only authorized personnel have access. B. all drugs and biologics must be stored in a manner to prevent access by nonauthorized individuals. 2. While on tour of ICU, Telemetry 1 and Telemetry 3 Units on 8/29/16 at approximately 1130, 1200 and 1230 hours, accompanied by staff N1 (Chief	S 1014	**S1014 410 IAC 15-1.5-7** **PHARMACEUTICAL SERVICES** (1-3) Medication refrigerators will be locked at all times to prevent access by non-authorized Individuals. Responsible Party: Nurses will be responsible for ensuring medication refrigerators remain locked at all times. Department Directors will be responsible for randomly checking medication refrigerators during their shifts to ensure compliance. Director, Plant Operations has reviewed all medication refrigerators and ensured a working locking device is available. CNO and COO will be responsible to monitor this standard to ensure compliance Completion Date: 12/27/16	12/27/2016

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	Financial Officer), the medication refrigerators were observed to be unlocked. 3. Staff N1 was interviewed on 8/29/16 at approximately 1230 hours and confirmed the medication refrigerators in the ICU, Telemetry 1 and Telemetry 3 Units were unlocked. Staff N1 confirmed facility was not following Policy 09-01, Medication Management - Storage.			
S 1178 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (e)(2) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (2) Refuse and garbage shall be collected, transported, sorted and			

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	disposed of by methods that will minimize nuisances or hazards. Based on document review, observation and interview, the facility failed to ensure secure storage of infectious waste in 5 (Emergency Department [ED}, Intensive Care Unit [ICU], Medical Surgical Unit, Telemetry 1 Unit, Telemetry 3 Unit) of 9 areas toured. Findings: 1. Policy IC 2.10, Biohazard Waste, revised/reapproved 09/30/2015 indicated on page 2: the boxes will be stored in the area behind decontamination for regular pickup by the medical waste disposal company. The door to this storage area will be labeled with "Biohazard" signage and will at all times be locked from the outside. 2. During tour of units ED, ICU, Medical Surgical, Telemetry 1 and Telemetry 3 on 8/29/16 at approximately 1115, 1130, 1200, 1230 and 1300 hours, accompanied by staff N1 (Chief Financial Officer), the soiled utility rooms containing infectious waste were observed	S 1178	**S1178 410 IAC 15-1.5-8 PHYSICAL PLANT** (1-3): Cypher locks will be placed on all soiled utility rooms containing infectious waste/biohazard items. Responsibility Party: The Plant Operations Director is responsible for placing cypher locks on each soiled utility room containing infectious/biohazard wastes. All soiled utility rooms have been identified and cypher locks will placed prior to close of business December 31, 2016. COO is responsible to ensure this standard is met. Completion Date: 12/31/2016	12/31/2016

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	unlocked/unsecured. 3. Staff N1 was interviewed on 8/29/16 at approximately 1300 hours and confirmed the soiled utility rooms containing infectious waste in the ED, ICU, Medical Surgical, Telemetry 1 and Telemetry 3 Units were unlocked. Staff N2 (Infection Control Preventionist) was interviewed on 8/30/16 at approximately 1400 hours and confirmed soiled utility rooms observed on tour were unlocked and contained infectious waste. Staff N2 confirmed facility was not following Policy IC 2.10, Biohazardous Waste.			