STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150017	A. BUILDING 00 B. WING	10/19/2011

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LUTHERAN HOSPITAL OF INDIANA	7950 W JEFFERSON BLVD FORT WAYNE, IN46804

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S0000	The visit was for a licensure survey. Facility Number: 005016 Survey Date: 10-03-11 to 10-05-11 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Saundra Nolfi, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 11/07/11	S0000		
S0102	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 employee file review and	S0102	The Director of Human	10/19/2011

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

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	interview, the facility failed to comply with all applicable federal, state, and local laws and rules for one of two PCA (patient care assistants) personnel files. (P6) Findings: 1. review of IC 16-28-13-4 indicated that: 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 health care facility; shall apply within 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 10-13-3 or another source by law." 2. at 3:35 PM on 10/18/11 and 10:45 AM on 10/19/11, review of personnel files for two PCA's hired in 2011 indicated staff member P6 was lacking documentation of the state nurse aide registry check per Indiana Code 16-28-13 3. interview with staff member NN at		Resources is responsible for addressing this issue. Following survey, Human Resource personnel completed the state nurse aide registry that was lacking in the personnel file that was reviewed and identified as lacking the appropriate documentation. This was completed on 10/19/11. The Director of HR will conduct a monthly audit of newly hired PCA's to assure compliance with the Indiana Code. Results of this review will be reported to the Quality Council.	

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	1:40 PM on 10/19/11, indicated it is not clear that the contracted agency doing the facility background checks is contacting the correct governmental agency, and documenting correctly, the nurse aide history of a non licensed patient care giver			
S0178	410 IAC 15-1.3-2(a) (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system. Based upon observation and interview, the facility failed to post a license copy in a common public area for each hospital services off-site location for 3 off-sites. Findings: 1. Lack of a posted license was observed in the common public areas of the following outpatient services: a) on 10-18-11 at 0930 hours, during a facility tour of the outpatient endoscopy suite.	S0178	A copy of the hospital license was posted in all off-site locations by the manager of each location on 11/11/2011. The Chief Quality Officer will be responsible in the future for assuring that a copy of the current license is posted in each off-site location. The Director of Environment of Care will verify the posting during Enviornment of Care rounds that are conducted semi-annually and this will be added to the rounding checklist. Results of EOC rounding are reported at the Environment of Care Committee and forwarded to the Hospital Quality Council.	11/05/2011

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	b) on 10-18-11 at 1520 hours, during a tour of the outpatient vascular lab. c) on 10-19-11 at 0935 hours, during a tour of the Lutheran Cath Lab at Dekalb Memorial Hospital. 2. During an interview on 10-18-11 at 0930 hours, staff #A2 confirmed the location lacked a posted license. 3. During an interview on 10-18-11 at 1520 hours, staff #A2 confirmed the location lacked a posted license. 4. During an interview on 10-19-11 at 0935 hours, staff #A19 confirmed the location lacked a posted license.			

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S0330	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 policy and procedure review, employee file review, and staff interview, the facility failed to implement its policy related to post offer physical examinations for 2 of 2 contracted dialysis nurses. (P7 and P8) Findings: 1. at 1:00 PM on 10/19/11, review of the policy and procedure "Health Services for Associates", (HR06.16), with a most recent date of 02/22/11, indicated: a. under "Purpose/Procedure", it reads: "1. Post-Offer Employment Physical Examinations A post-offer employment examination performed by Hospital personnel is required as a condition of	S0330	The Chief Nursing Officer communicated the ISDH licensure survey finding with the Manager of the Diaylsis unit on 10/19/11. The Dialysis Unit Manager will update all employee files with documentation of the post-offer physical examination. The Administrative Director of Nursing will be responsble for auditing quarterly a sample of the files to assure compliance. Audit results will be reported to and reviewed by the Hospital Quality Council.	11/05/2011

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	employment..." 2. review of contracted dialysis nursing files P7 (first date worked 7/25/11) and P8 (first date worked 3/15/11), at 1:20 PM on 10/19/11, indicated neither file contained documentation of a physical examination 3. interview with staff member NA at 1:50 PM on 10/19/11, indicated there was no post offer physical examination information in either P7 or P8 employee files			
S0394	410 IAC 15-1.4-1(f)(3) (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: (3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided. Based on document review, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 19 contracted services. Findings:	S0394	The Chief Quality Officer (CQO) is responsible for maintaining the list of all contracted services. The contract list will be updated by December 19th. Annually the CQO will review and update the list of all contracted services which will be presented to the Medical Executive Committee and Governing Board for their review	11/04/2011

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	1. On 10-17-11 at 1430 hours, a list of contracted services was received from staff #A1. The list of services failed to indicate a service provider for an air ambulance, biohazardous waste, boilers, CT scanner, elevator, exhaust hoods, fire services, generator, medical gasses, medical transcription, MRI scanner, OR monitoring, patient beds, pest control, and sterilizers. 2. Review of facility documentation indicated the following: Air Ambulance Services were provided by SP1, biohazardous waste service was provided by SP2, boiler service and certification was provided by SP3, CT scanner service was provided by SP4 and SP5, elevator service was provided by SP6, exhaust hoods were inspected by SP7, fire service providers included fire panel monitoring by SP8, sprinkler service by SP9, fire pump testing by SP10, and fire extinguisher service by SP11, generator service by SP12, medical gas service by SP13, medical transcription by SP14, MRI scanner service by SP5 and SP15, OR environmental monitoring by SP16, patient bed service by SP17, pest control		and approval.	

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	service by SP18, and sterilizer service by SP19. 3. On 10-19-11 at 1335 hours, staff #A5 and #A7 confirmed the list of contracted services failed to include the providers identified through facility documentation.			
S0554	410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.	S0554	The laboratory supervisor of point of care testing shall provide an inservice to all hospital personnel responsible for glucometer testing. This inservice shall address the procedure for following the manufacturer's directions for dating glucometer strips and control solutions. The inservicing will be completed by January 19, 2012. The Hospital Tracer Teams shall add this issue to the tracer checklist and shall report the results monthly to the Nursing Quality Council. This process will be initiated in February 2012 . During the survey it was noted that a soft drink was found in the morgue refrigator designated for specimens. The drink was immediately removed. The	10/19/2011

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			Environment of Care(EOC) rounding team will conduct follow-up checks of the morgue to assure compliance. Results of the EOC rounding team findings will be reported to the appropriate department and to the Environment of Care Committee on a quarterly basis.	

Based on observation, document review, and interview, the facility failed to follow manufacturer's directions for dating glucometer strips and control solutions to prevent outdated usage on all of the nursing units toured and failed to ensure a refrigerator in the Morgue designated for specimens does not store staff drinks within it.

Findings included:

1. During the tour of the Pediatric Unit at 12:50 PM on 10/17/11, accompanied by staff members NB, NI, and NJ, it was observed that the glucometer control solutions were dated , by nursing staff, with 10/21/11 and the strips were not dated.

2. During the tour of the Emergency Department at 1:00 PM on 10/17/11, accompanied by staff members ND and NE, it was observed that the glucometer control solutions were dated , by nursing staff, with 10/21/11 and the strips were

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	not dated. 3. During the tour of the Neuro/Spine Unit at 2:00 PM on 10/17/11, accompanied by staff members NE and NF, it was observed that the glucometer control solutions were dated , by nursing staff, with 10/21/11 and the strips were not dated. 4. During the tour of the Pediatric Intensive Care Unit at 2:30 PM on 10/17/11, accompanied by staff members NB and NI, it was observed that the glucometer control solutions were dated , by nursing staff, with 10/21/11 and the strips were not dated. 5. During the tour of the Oncology Unit at 3:00 PM on 10/17/11, accompanied by staff members NB and NM, it was observed that the glucometer control solutions were dated , by nursing staff, with 10/21/11 and the strips were dated as opened 10/13/11 and an expiration date of 01/13/12. 6. During the tour of the Childbirth Center at 9:15 AM on 10/18/11, accompanied by staff members NE and NN, it was observed that one set of glucometer control solutions was dated , by nursing staff, with 10/21/11 and a second set was dated 10/21/11 and			

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	10/25/11. 7. During the tour of the Day Surgery at 11:10 AM on 10/18/11, accompanied by staff members NB and NZ, it was observed that the glucometer control solutions were dated , by nursing staff, with 10/21/11, and the strips were dated 10/11/11. 8. During the tour of the Neonatal Intensive Care Unit at 11:25 AM on 10/18/11, accompanied by staff members NE and NO, it was observed that the glucometer control solutions were dated , by nursing staff, with 10/17/11, and the strips were dated 10/01/11. 9. During the tour of the Coronary Intensive Care Unit at 1:05 PM on 10/18/11, accompanied by staff members NE and NQ, it was observed that the glucometer control solutions were dated , by nursing staff, with 01/11/12, and the strips were dated 04/17/12. 10. During the tour of the Medical/Surgical 4 Unit at 2:45 PM on 10/18/11, accompanied by staff members NE and NU, 3 glucometer kits were observed. One kit contained strips marked with an expiration date of 12/10/11 and 3 bottles of control solution with no dates. The second kit contained			

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	strips with an open date of 10/15/11 and 2 bottles of control solution with no dates. The third set contained strips with no dates and 4 bottles of control solution, 2 with no dates, and 2 with faded, unreadable dates. 11. The StatStrip Operator Training Program for the StatStrip Glucose Monitoring System stated on page 5, "Glucose Test Strips- Always Date Vials When Opened, ...Once opened the test strips are stable at room temperature for up to 180 days or until the expiration date, whichever is first. Write the date opened and discard date on the vial." The instructions continued, "Quality Control Solutions- Always date vials when opened. ...Once opened, Quality Control is stable for up to 90 days or until the expiration date, whichever is first. Write the discard date on each vial." 12. At 12:55 PM on 10/17/11, staff member NJ on the Pediatric Unit indicated he/she was unsure of how the glucometer supplies should be dated or the expiration time. 13. At 1:10 PM on 10/18/11, staff member NQ on the Coronary Intensive Care Unit indicated the strips were good for 60 days and the controls were good for 90 days.			

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	14. At 3:00 PM on 10/18/11, staff members NE and NV confirmed that the staff was unclear regarding dating the strips and controls and correct length of time before expiration. 15. At 12:15 PM on 10/19/11, staff member NB provided training documentation for all staff using the glucometer that was conducted during the month of July 2011. 16. At 1:15 PM on 10/17/2011, the Morgue was toured. A pathology refrigerator in the Morgue labeled with a sign that states, "No Food & Drink to be stored in Refrig." There was a biohazard label on the refrigerator. The refrigerator door was open and there was assortment of containers with specimens from previous autopsies. Beside the specimens was a half filled container of 'Sprite Zero' also on a shelf.			

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S0596	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 observation and interview, the infection control practitioner failed to ensure the prevention of contamination of the clean/sterile instrument area from the decontamination area, of the South Endoscopy unit, in relation to the pass through window. Findings: 1. at 9:45 AM on 10/18/11, while touring the South Endoscopy off site unit, in the company of staff members NE and NK, it was observed that the pass through window separating the contaminated area for instrument cleaning, and the clean instrument/scope room was left open and staff were not currently passing instruments/scopes during the time of the tour	S0596	Following survey, staff in both Endoscopy locations were made aware of the finding related to the pass through window. The Director of the Endoscopy shall be responsible for assuring compliance with this requirement. The Environment of Care (EOC) Rounding Team will audit compliance during monthly rounds. Any issues of non-compliance will be immediately report to the unit director. The Quality Council will review the results of the EOC rounding team and take further action as required.	11/04/2011

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	2. interview with staff members NE and NK indicated: a. staff currently decontaminating instruments were asked if they were currently passing items through the window and responded "no", they were not			
S0598	410 IAC 15-1.5-2(f)(3)(D)(iv) (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: (iv) Aseptic technique, invasive procedures, and equipment usage. Based on policy and procedure review, observation, and interview, the infection control committee and surgery manager failed to implement the facility policy related to surgical masks. Findings: 1. at 12:30 PM on 10/17/11, review of the policy and procedure "O.R. (operating room) Dress Code", (Policy # 4.02.04), with a last revised date of July 2010, indicated:	S0598	The Director of Surgery shall be responsible of enforcing the Hospital Policy related to the OR Dress Code, specifically the issue of "masks left dangling around the neck." The OR Director was made aware of the survey finding on 10/20/11. All staff that work in the OR and other surgical locations will be inserviced as to the policy requirements by the Director of Surgery. Inservicing shall be completed by 12/16/11. In addition to the monitoring done by the Direcotr of	10/20/2011

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	a on page 2 in section H. "Masks and Eye Shields:", it reads in Masks will not be left dangling around the neck..." 2. on 10/18/11 at 1:20 PM, while on tour of the surgery department in the company of staff member NZ, it was observed that: a. several staff members were noted in the inner core, and entering the Pre/Post op area from the surgery area, with surgical masks around the neck 3. on returning to the Board Room from the surgery area at 2:10 PM on 10/18/11, in the company of staff member NZ, it was observed that: a. a staff person in blue surgical scrub was noticed transporting a gurney through the hallway to a patient elevator with a surgical mask around the neck 4. interview with staff member NZ at 1:30 PM and 2:10 PM on 10/18/11 confirmed that: a. the staff member noticed in the hallway with a patient gurney, was a staff member of the attached orthopedic hospital b. surgical masks are not to be worn dangling about the neck, as per facility policy, whether they are hospital employees or attached hospital employees		Surgery, the Enviornment of Care Tracer Team and the Hospital Joint Commission Tracer Teams will add this to their monthly monitoring activities and shall report any failure to the Director Surgery as well as to the Environment of Care Committee and Nursing Quality Council. Results of this monitoring activity will be reported to the Hospital Quality Council.	

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	150017	A. BUILDING 00 B. WING	10/19/2011

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S0606	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: (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 policy and procedure review, employee record review, and staff interview, the associate health staff failed to implement the facility policy related to TB (tuberculosis) testing for 2 of 2 PCAs (patient care associates/assistants), P1 and P6, and 1 of 2 contracted dialysis nurses, P8; and failed to ensure the status of Varicella immunity for 1 of 3 RNs (registered nurses) hired in 2011, P20. Findings: 1. at 11:15 AM on 10/19/11, review of the Infection Control policy "Preventing the Transmission of Tuberculosis", Policy 03.49G, indicated: a. on page two under "Surveillance of all associates, students and volunteers	S0606	Employee Health Services reports to the Director of Human Resources. Following the ISDH licensure survey the Employee Health staff was made aware of the hospital policy requirements related to TB testing and communicable disease history documentation. The Director of Human Resources/designee shall audit monthly a sample of employee records to assure compliance with hospital policy requirements related to TB testing and communicable disease history documentation. Audit results shall be reported to the Infection Control Committee. Results of the audit will also be reported to and reviewed by the Hospital Quality Council.	10/20/2011

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	includes 2 step baseline tuberculin skin testing (TST) upon employment,..." 2.. at 11:20 AM on 10/19/11, review of the "Tuberculin Skin Testing (TST) 2011 Plan", indicated: a. under the title "CDC (centers for disease control) Guidelines recommended screening frequency for the low risk classification:", it reads: "1. Baseline two-step TST...or IGRA (Interferon Gamma Release Assay) for all HCW's (health care workers) upon hire." b. under the title "2011 TST Plan for Lutheran Hospital approved by Infection Control Committee 12/1/10", it reads: "1. Baseline two-step TST...or IGRA...for all HCW's upon hire." 3. review of employee files at 3:35 PM on 10/18/11 and 10:45 AM on 10/19/11 indicated: a. staff member P1 was hired 2/23/11 and had only 1 TB test done 2/10/11 (read 2/13/11) b. staff member P6 was hired 7/11/11 and had only 1 TB test that was read on 7/8/11 c. contracted dialysis nurse P8 first worked on 3/15/11 and had only 1 TB test dated 4/18/11 4. interview with staff member NM at 1:00 PM on 10/19/11 indicated:			

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	a. staff members P1, P6 and P8 had previous TB test documentation, from a former employer, that was accepted as their first of the two step testing process b. the policy "Preventing the Transmission of Tuberculosis", stated in 1. above, does not address being able to accept a previous employer's TB test results c. the associate health has a policy (41.02) that does allow a TB test that was within 12 months of hiring at the facility, but conflicts with the facility's most current, 2011 "Plan", as listed in 2. above 5. at 1:00 PM on 10/19/11, review of the policy and procedure "Health Services for Associates" (File: HR06.16), indicated: a. under "Purpose/Procedure", it reads: 1. Post-offer Employment...laboratory tests such as...varicella screen for those without a reliable history or with uncertain history of varicella..." 6. review of employee files at 3:35 PM on 10/18/11 and 10:45 AM on 10/19/11 indicated: a. staff member P20 was hired 1/31/11: A. had a self reported history of disease B. had a notation on 3/9/11, made by associate health staff that the employee needed a varicella titer C. had a copy of the memo/order sent			

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	to staff member P20 for a "Chicken Pox titer ASAP" (as soon as possible) that was dated 3/9/11 7. interview with staff member NM at 1:00 PM on 10/19/11 indicated: a. it is unknown why there was no follow up with staff member P20 after the 3/9/11 memo was sent to the staff member b. staff member P20 has an unknown communicable disease history for varicella			

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S0610	410 IAC 15-1.5-2(f)(3)(D)(x) (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: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on policy and procedure review, observation, and staff interview, the facility and infection control committee failed to ensure the implementation of its policy related to refrigerator temperature checks in two areas toured. (Radiology and the Emergency Department) Findings: 1. at 3:10 PM on 10/17/11, review of the policy "Refrigerator/Freezer Temperature	S0610	The Quality Manager will communicate to the Radiology and the Emergency Departments the hospital's policy related to refrigeratior temperature checks. The Environment of Care Rounding Team and the Hospital Tracer Team will audit both areas monthly to determine compliance with the hospital policys Audit results shall be shared with the involved departments as well as the Environment of Care Committee. The Environment of	10/20/2011

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	Check/Documentation" (File GN01.12), indicated: a. under "1.0 Position/Policy Statement", it reads: "There must be a routine checking of the temperatures in the refrigerators and freezers to ensure consistent temperature levels. This check will include documentation of temperature readings, corrective action if reading is outside accepted range and signature of person performing the check. These temperature checks will be performed daily on all refrigerators: patient, medication, and employee." b. under "Purpose/Procedure", it reads: "2.1 Nutritional Services will be responsible for performing daily refrigerator/freezer checks on the patient refrigerators...2.6 The acceptable refrigerator temperature range is from 30 degrees to 42 degrees..." 2. at 1:00 PM on 10/17/11, while on tour of the ED (emergency department) in the company of staff members ND and NE, it was observed that: a. the form used by ED staff is titled "Emergency Services Equipment Verification Form" and indicated: A. the patient refrigerator temperature on 10/17/11 was 50 degrees, which was out of the normal range for the maximum high, but lacked indication of adjustment or contact with maintenance staff to check		Care Committee shall report the above findings to the Quality Council.	

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	the operation of the equipment B. the patient refrigerator was 46 degrees on 9/18/11 which was out of the normal range for the maximum high, but lacked indication of adjustment or contact with maintenance staff to check the operation of the equipment C. the staff refrigerator was below the recommended 35 degrees on 9 days in October 2011 (10/3; 10/4; 10/7; 10/10; 10/12; 10/13; 10/14; 10/16 and 10/17/11) and 4 days in September 2011 (9/23; 9/25; 9/27 and 9/30) D. neither the staff refrigerator, nor the patient refrigerator, had the daily temperature checks completed/documented for 2 of 17 days in October (10/1/11 and 10/6/11) and for 10 of 30 days in September (9/5; 9/9; 9/10; 9/11; 9/12; 9/14; 9/15; 9/19; 9/22 and 9/26/11) 3. interview with staff members ND and NE at 1:15 PM on 10/17/11 indicated: a. it was unknown that the food code indicates food temperature to be below 41 degrees, not 35 to 45 degrees listed on the form ED staff are using b. ED staff are not utilizing the correct refrigerator temperature logs, as per policy, that would indicate a temperature range of 35 to 42 degrees, (still not in line with food code's < 41 degrees) c. it is unknown why nursing staff did			

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	not document adjustment to the refrigerator, or contact with maintenance, when the refrigerators were above (or below) the allowed/recommended temperatures d. it is unknown why there are days that lacked documentation of the refrigerator temperatures for both the staff and the patient refrigerators 4. at 11:05 AM on 10/18/11, while on tour of the radiology department in the company of staff member NH, it was observed that: a. the staff refrigerator temperature log, located in the break room, for October 2011 was blank--there was no temperature logged for any of the 18 days of this month 5. interview with staff member NH at 11:10 AM on 10/18/11, indicated radiology staff were responsible for documenting daily refrigerator temperature checks			

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S0726	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 policy and procedure review, and interview, the facility failed to ensure the security of patient medical records in two areas toured. Findings: 1. at 12:15 PM on 10/18/11, review of the policy and procedure "Medical Record Access and Documentation Guidelines" (PTO 3.18), with a most recent date of 02/03/09, indicated: a. on page 4 under item 3.8, it reads: "In the event that the original medical record is kept on the unit, department, or clinic for continuing care purposes, the unit, department, or clinic is responsible	S0726	The Quality Manager shall provide the Endoscopy Department (North and South)Director with the Hospital policy and procedure relate to Medical Record Access and Documentation Guidelines. The inservice shall relate to how medical records are to be secured after hours. As part of the Quality Department's staff knowledge interviewing process and tracer rounds that are completed monthly, Endoscopy staff will be questioned as to how and where records are stored after hours. Results of this process shall be reported to the Endoscopy Department Manager and the Hospital Quality Council.	11/05/2011

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	for maintaining the confidentiality and security of the information..." 2. while touring the South Endoscopy off site unit in the company of staff members NE and NK at 9:50 AM on 10/18/11, it was discovered, by interview, that: a. patient medical records are kept on the unit after hours and returned to the main hospital medical records department the following day b. housekeeping staff clean the unit after hours, when the unit is closed and nursing staff are gone c. patient medical records are not locked and secure after hours 3. while touring the North Endoscopy unit in the company of staff members NE and NK at 10:40 AM on 10/18/11, it was discovered, by interview, that: a. physician patient records, from their offices, are on the unit the evening prior to the patients' procedures, but are not locked/secured after hours b. housekeeping staff are present in the unit after hours when nursing staff are gone			

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S0751	410 IAC 15-1.5-4(f)(2) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (2) The medical history and physical examination of the patient done within the time frames as prescribed by the medical staff rules and section 5 (b)(3)(M) of this rule. Based on medical record review, policy review, and interview, the facility failed to ensure the History and Physical was performed according to policy for 1 of 3 newborn infants (#N23). Findings included: 1. Review of medical record #N23, an infant male born at 0153 on 10/16/11, lacked documentation of the physician's initial physical exam. Two exams were documented under the discharge exam. There was a physician signature for each exam, 2 dates, 10/17/11 and 10/18/11, but no times. 2. The Medical Staff Policy regarding History and Physical, last revised 07/12/11, stated, "...A. A complete history and physical examination shall be performed and documented no more than 30 days prior to or within 24 hours after admission as inpatient or observation	S0751	The Director of Medical Records and the Chief Medical Officer shall address the noted deficiency with the medical staff through the Medical Excutive Committee. The Quality Department currently monitors compliance with this requirement monthly and reports this information to the Hospital Quality Council and Medical Executive Committee. Physicians not meeting this requirement will notified in writing of the deficiency.	11/05/2011

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	status, or prior to surgery whichever comes first." 3. At 10:10 AM on 10/18/11, staff member NAA on the obstetrical unit confirmed the lack of a physical exam within 24 hours for patient #N23. 4. At 11:55 AM on 10/19/11, staff member NB indicated the Medical Staff Policy provided covered both adults and newborns.			

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S0912	410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (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: (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. Based on policy and procedure review, observation, document review, medical record review and interview, the nursing executive failed to ensure that nursing staff implemented the policy related to blanket warmer temperatures in the ED	S0912	The Administrative Director of Nursing shall be responsible for educating the Emergency Department staff on the policy related to blanket warmer temperatures and fall risk assessment and intervention. Compliance with the policies shall	10/20/2011

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	(emergency department) and failed to ensure the fall risk assessment and interventions were done per facility policy for 9 of 28 adult patient charts reviewed (#N5, N6, N26, N27, N28, N29, N30, N31, and N32). Findings included: Findings: 1. at 3:10 PM on 10/17/11, review of the policy and procedure "Warming Cabinet Protocol..." (Policy # 1.20.25) with a last revised date of May 2011, indicated: a. under section II. "Rationale", it reads "Controlled temperatures of warmed contrast, fluid and blankets will ensure patient safety. Proper loading of warmers and daily temperature checking will ensure the cabinets are functioning properly..." b. under section IV. "Position/Policy Statement", it reads "...B. Select departments have warming cabinets for warming blankets for patient use. Warming cabinets will be maintained at a temperature no higher than 130 degrees.." c. under section V. "Procedure", it reads "...6) Temperatures in warming cabinets will be checked daily by the designated department staff and documented on the Blanket Warmer Temperature Checklist..."		be monitored through the monthly Quality Department Tracer Activity. Audit findings will be reported to the Chief Nursing Officer, the Administrative Director of Nursing and the Emergency Department Nurse Manager. In addition, findings will be reported to and reviewed by the Environment of Care Committee and the Hospital Quality Council.	

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	2. while on tour of the ED at 1:05 PM on 10/17/11, while in the company of staff members ND and NE, it was observed that: a. the form titled "Emergency Services Equipment Verification Form" was being utilized for checking warming cabinet temperature, not the facility approved form b. the "Emergency Services Equipment Verification Form" states that "Temperature must be maintained at 130 degrees" c. there are two blanket warmers being checked by the ED staff: one in the trauma room and one in the stock room d. all of the days the trauma warmer was checked in September and October were > 130 degrees, with the highest temperatures of 139 degrees on 9/6/11 and 9/28/11 e. all of the days the stock room warmer was checked in September and October were > 130 degrees, with the highest temperature of 140 degrees on 9/30/11 f. both warmers lacked having the daily temperature checks completed/documented for 2 of 17 days in October (10/1/11 and 10/6/11) and for 10 of 30 days in September (9/5; 9/9; 9/10; 9/11; 9/12; 9/14; 9/15; 9/19; 9/22 and 9/26/11)			

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	150017	A. BUILDING 00 B. WING	10/19/2011

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	3. interview with staff members ND and NE at 1:15 PM on 10/17/11 indicated: a. it was unknown why there were no temperature checks of the warmers for 1/3 of the days of September and two days, so far, in October 4. interview with staff member NE at 3:15 PM on 10/17/11 indicated: a. the ED staff are utilizing the wrong form to document warmer temperature checks b. the ED staff are maintaining the warmers higher than facility policy dictates 5. The facility policy, "Category- Safety, Detail- Eliminating Falls and Falls with Serious Injuries (Adult) and What to do when a Fall Occurs", revised September 2011, stated under Policy Statement, "...The Morse Fall Scale is a reliable tool with a high degree of measured predictive reliability. The protocol is designed to identify patients who are at risk for falls and describe interventions that are used to ensure patient safety." The policy continued under Procedure, "A. Assess risk of falling and risk for serious injury from a fall using the following (4) questions and thereafter the Morse Fall Scale every eight (8) hours and immediately after a fall."			

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	Page 3 of the document listed the various interventions that should be implemented based on the fall score. A fall risk score of 25-44 placed the patient at moderate risk and one of the interventions was , "Review medications for side effects that increase the risk of falls, i.e., narcotics, sedatives, antihypertensives, etc. Discuss with physician for viable alternatives." A fall risk score of greater than 45 placed the patient at high risk and all of the other interventions should be in place and additionally, "apply a bed alarm, move sensor pad to chair if patient is sitting in chair". 6. Review of open medical records indicated the following: A. Patient #N5 was admitted on 10/15/11 and had a fall assessment done that day at 0800 (score 50) and 2138 (score 55), none on 10/16/11, and one at midnight and again at 0800 on 10/17/11. B. Patient #N6 was admitted on 10/13/11 and had fall assessments done at 0736 (score 35) and 2000 (score 35) on 10/14/11 and 0140 (score 35) and 2015 (score 45) on 10/15/11. C. Patient #N26 was admitted on 10/15/11 and had fall assessments at 1950 (score 35) on 10/15/11, 0521 (score 35), 1000 (score 35), and 2201 (score 35) on 10/16/11, 0255 (score 35), 0637 (score 35), and 2224 (score 35) on 10/17/11.			

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	D. Patient #N27 was admitted on 10/11/11 and had fall assessments at 1558 (score 35) on 10/14/11, 1622 (score 50) on 10/15/11 with no documentation of a bed alarm, none on 10/16/11, and 0850 (score 45) on 10/017/11 with documentation of a bed alarm. E. Patient #N28 was admitted on 10/14/11 and had fall assessments at 2340 (score 85) on 10/14/11, 0815 (score 85) and 2100 (score 85) on 10/15/11 with no documentation of a bed alarm, 0730 (score 75) and 2002 (score 85) on 10/16/11, and only one on 10/17/11 at 0743 (score 75). F. There was no documentation related to, or it could not be determined how, the "Review medications for side effects that increase the risk of falls ...," was performed per policy , when the patient scores were 25- 44 or greater. 7. Review of closed medical records indicated the following: A. Patient #N29 was admitted on 07/27/11 and had fall assessments at 0831 (score 50), 1400 (score 50) with no documentation of a bed alarm, and 2200 (score 50) with alarm on 10/27/11, 0600 (score 50), 0723 (score 75), and 2154 (score 75) on 07/28/11. B. Patient #N30 was admitted on 08/09/11 and had fall assessments at 1057 (score 75) with no alarm and 2042 (score			

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	75) with alarm on 08/09/11 and 0805 (score 75) and 2030 (score 85) on 08/10/11. C. Patient #N31 was admitted on 08/13/11 and had fall assessments at 0633 (score 35) and 1600 (score 35) on 08/13/11, none on 08/14/11, and 2322 (score 35) on 08/15/11. There was documentation that the patient was intubated and on a bed alarm on 08/15/11 which raised questions as to the accuracy of the score. D. Patient #N32 was admitted on 08/14/11 and had fall assessments at 0200 (score 60), 0900 (score 60), and 2030 (score 60) on 08/15/11, all with no alarm, 0800 (score 70) with no alarm and 1600 (score 70) with alarm on 08/16/11. E. There was no documentation related to, or it could not be determined how, the "Review medications for side effects that increase the risk of falls ...," was performed per policy , when the patient scores were 25- 44 or greater. 8. At 1:30 PM on 10/18/11, staff member NR on CICU, indicated the fall assessments had to be done once a shift and the shifts were usually 12 hour shifts. 9. At 2:25 PM on 10/18/11, staff member NS on CICU, indicated he/she placed a bed alarm on patient #N27 today even though the patient had a fall risk score of			

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	45 and 50 for previous shifts. 10. At 3:05 PM on 10/18/11, staff member NV confirmed the fall assessments and interventions were not done according to policy.			
S0952	410 IAC 15-1.5-6(d) (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 document review, medical record review, and interview, the facility failed to ensure staff followed their policy for blood administration in 2 of 3 records reviewed of patients who had received blood transfusions on the units (#N5 and N18). Findings included: 1. The facility's Blood Transfusion Form listed a "fever (Increase in temperature greater than 2 degrees F. (Fahrenheit) with or without fever" as a possible indicator	S0952	The Administrative Director of Nursing developed a corrective action plan to deal with the above issue.The Administrative Director of Nursing will share the results of the ISDH survey with the Nursing Managers at the December Nursing Division Director meeting. Nursing Management will then be responsible for sharing this information with front-line staff at regularly scheduled unit meetings. The Administrative Director of Nursing will share blood administration audit results with the nurse managers monthly	11/04/2011

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	of a blood transfusion reaction. The form also indicated the vital signs were to be taken after 15 minutes and at 1 hour, 2 hours, and 3 hours from the start time. 2. Review of medical record #N5 indicated a unit of blood was started at 1535 (time was written over/changed) on 10/09/11 and the 1 hour vital signs (VS) were taken at 1650 and the 2 hour VS were taken at 1750. Another unit of blood was started at 1150 (again time was written over/changed) on 10/11/11 and the 1 hour VS were taken at 1300 and the 2 hour VS were taken at 1400. The completion VS for this unit were lacking a temperature. 3. Review of medical record #N18 indicated a unit of blood was started at 1325 on 10/10/11 with the 1 and 2 hour VS recorded as 1445 and 1550. A second unit of blood was started at 1620 on 10/10/11 with the 1 and 2 hour VS recorded as 1750 and 1850. Medical record #N18 indicated a unit of blood was started at 1426 on 10/11/11, but lacked documentation of 1 and 2 hour VS. The starting temperature was 98.2 degrees F. and the completion temperature was 100.4 degrees F., an increase of greater than 2 degrees, but there was no report of a possible blood transfusion reaction.		with a goal of 95%. The Hospital Quality Council will be responsible for reviewing audit results and corrective action.	

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	Medical record #N18 indicated another unit of blood on 10/14/11. The start time was 1350 and the 1 hour time was written as 1505, but no VS were documented for that time or for 2 hours after the start time. 4. At 3:00 PM on 10/17/11, staff member NB indicated the Blood Transfusion Form was the document to follow and the VS were to be taken 1 hour after the start time, not 1 hour after the 15 minute VS.			
S1024	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 observation and interview, the facility failed to ensure outdated medications, intravenous antibiotics, and irrigation solutions were removed form the medication refrigerators on 3 nursing units and medications were removed after	S1024	Those units with outdated items were notified the day of survey and items were removed. The Administrative Director of Nursing shall review the findings of the ISDH licensure survey with the Nursing Division Directors at the next Nursing Division Director meeting - 12/22/2011. Nurse	10/19/2011

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	patients were discharged. Findings included: 1. During the tour of the Pediatric Unit at 12:50 PM on 10/17/11, accompanied by staff members NB, NI, and NJ, the following items were observed in the medication refrigerator: A. A bag of Neomycin- Polymyxin solution for bladder irrigation with an expiration date and time of 09/13/11 at 2145. The patient had been discharged on 09/14/11. B. A plastic bag containing 2 retail pharmacy bottles of liquid medication, Cephalexin suspension and Sulfamethoxazole suspension. The patient had been discharged 10/14/11. C. A syringe of Claforan with an expiration date and time of 10/16/11 at 2205. 2. During the tour of the Nursery at 11:10 AM on 10/18/11, accompanied by staff members NE and NN, the following items were observed in the medication refrigerator: A. An intravenous (IV) bag of Penicillin 2,500,000 Units, labeled as "Stat-prepared 10/17/11 at 0609". B. An IV bag of Penicillin 2,500,000 Units with an expiration date and time of 10/18/11 at 0925.		Managers will be responsible for sharing this information with front-line staff. The Environment of Care Rounding Team currently looks for outdated items during their rounds. This information is collected and trended and shared with unit as well as the Environment of Care Committee. The information will be reported to and reviewed by the Hospital Quality Council.	

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	C. An IV bag of Kefzol 1 Gram with an expiration date and time of 10/17/11 at 1100. 3. During the tour of the Medical/Surgical 4 Unit at 2:35 PM on 10/18/11, accompanied by staff members NE and NU, a plastic bag containing a bottle of Vancomycin oral suspension for a patient who had been discharged on 10/16/11. 4. At 1:15 PM on 10/17/11, staff member NI indicated it was the charge nurse's responsibility to remove the medications from the refrigerators.			
S1118	410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation, staff interview, and document review, the facility failed to ensure exposed electrical wiring was prevented in the kitchen cafeteria, failed to ensure that a condition was not created	S1118	The Director of Facilities Management corrected the cited deficiencies that were identified in the hospital cafeteria - fixture shielding - was replaced on 10/19/11 and the nitrogen gas cylinders were secured as required at the time of the finding	10/19/2011

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	that could be a hazard to patients in relation to expired products in four areas toured (neuro/spine nursing unit, radiology, surgery and pediatric intensive care), failed to ensure the staff's safety in the soiled room of the Obstetrical Surgical rooms and failed to store patient tube feedings according to manufacturer's instructions and failed to safely store and maintain 15 compressed nitrogen cylinders which resulted in a hazard to patients and employees of the facility. Findings included: 1. At 12:30 PM on 10/18/2011, the hospital kitchen cafeteria was toured. The hot bar steam table was inspected and there were 2 long hanging light fixtures mounted over the exposed food. The LED lighting system was observed missing the fixtures shielding. Wiring to the LED lighting system was observed exposed to touch and splash from food and staff on both light fixtures. 2. At 12:45 PM on 10/18/2011, staff member L18 indicated the two light fixtures were old and the plastic shielding for the lighting system was missing from both light fixtures. 3. Lutheran Hospital Safety Management		and an eyewashing device will be installed in the obstetrical unit.The Quality Manager shall address the deficiencies related to expired items and the appropriate storage of tube feedings(materials which contain light sensitive nutrients) with all the areas noted. Auditing shall be conducted through monthly Quality Tracer Team Rounding with results shared directly with the Unit Manager and with the Environment of Care Committee. The information will be reported and reviewed by the Hospital Quality Council.	

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	Plan EC.01.01.01.4 effective 1/20/2011 states, "Scope: The Safety Management Plan describes the programs used to design, implement, and monitor a program to manage safety for patients, staff, and visitors for Lutheran Hospital and its offsite locations and to assure compliance with applicable codes and regulations." 4. Lutheran Hospital policy requires all areas to meet OSHA codes as defined in the hospital's safety management plan. OSHA 1919.303 states, "Electric equipment shall be free from recognized hazards that are likely to cause death or serious physical harm to employees." 5. at 1:50 PM on 10/17/11, while on tour of the neuro/spine nursing unit in the company of staff members NE and NF, it was observed that >9 blue topped swab culture tubes expired 8/11 6. interview with staff member NF at 1:55 PM on 10/17/11 indicated it was nursing staff responsibility to check for expiration dates on supplies 7. at 2:10 PM on 10/17/11, while on tour of the pediatric intensive care unit in the company of staff member NB, it was noted that 13 light green top lab tubes expired 09/2011			

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	8. at 11:10 AM on 10/18/11, while on tour of the radiology department in the company of staff member NH, it was observed that the ambu bag expired 12/2007 9. at 1:40 PM on 10/18/11, while on tour of the surgery department in the company of staff member NZ, it was observed in the Malignant Hyperthermia cart that the following lab tubes had expired: a. one yellow top tube exp. 10/10 b. one blue top tube exp. 12/10 c. 2 purple top tubes exp. 6/11 10. interview at 1:45 PM on 10/18/11 with staff member NZ indicated the nursing staff checks the Malignant Hyperthermia cart on a monthly basis and should have discovered the expired tubes during those checks 11. interview with staff member NA at 2:47 PM on 10/19/11 indicated: a. the monthly checks of supplies is performed by central/sterile supply, not nursing, as was indicated by all nursing staff on the floors as interviewed b. there is no facility policy/procedure related to checking of expiration dates on ambu bags, supplies, lab tubes, etc. c. the nursing units could not produce monthly checklists for the past three			

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	months, as requested by the surveyor, to document that the monthly checks had been occurring, as was stated by nursing staff when interviewed 12. During the tour of the obstetrical area at 9:50 AM on 10/18/11, accompanied by staff members NE and NN, the sink used for cleaning soiled surgical instruments was observed without an eyewashing device. 13. The label on the Zolvstat enzymatic cleaner indicated the eyes should by flushed for 15 minutes if splashed with the chemical. 14. At 10:00 AM on 10/18/11, staff member NP indicated the surgical instruments were cleaned with the enzymatic cleaner before sending them to central sterilization. He/she indicated he/she wore protective equipment, but still had been splashed. He/she indicated the nearest eyewash station was located on another floor of the hospital. 15. The facility's Safety Management Plan, dated 03/14/11, stated under Scope, "The Safety Management Plan describes the programs used to design implement and monitor a program to manage safety for patients, staff and visitors for [the facility] and its offsite locations and to			

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	assure compliance with applicable codes and regulations." 16. During the tour of the Coronary Intensive Care Unit at 1:10 PM on 10/18/11, accompanied by staff members NE and NQ, 2 bottles of Oxepa tube feeding, 2 bottles of Optimental tube feeding, and 2 bottles of Promote tube feeding were observed on an open shelf in the nourishment room. The labels on all of the bottles indicated "contains light sensitive nutrients". 17. During the tour of the Medical/Surgical 4 Unit at 2:35 PM on 10/18/11, accompanied by staff members NE and NU, a bottle of Promote tube feeding was observed on an open counter by the refrigerator. The label on the bottle indicated "contains light sensitive nutrients". 18. At 1:50 PM on 10/18/11, staff member NE spoke with the dietary director, staff member NT, who indicated the tube feedings should be stored in a cupboard or cabinet. 19. Review of the Occupational Safety and Health Administration (OSHA) general requirements for compressed gasses in 29 Code of Federal Regulations			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOSPITAL OF INDIANA	7950 W JEFFERSON BLVD FORT WAYNE, IN46804

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	(CFR) 1910.101 indicated the following: Per 29 CFR 1910.101(b), the in-plant handling, storage and utilization of all compressed gas cylinders must be in accordance with Compressed Gas Association (CGA) Pamphlet P-1 Safe Handling of Compressed Gas Cylinders. " Gas cylinders should be properly secured at all times to prevent tipping, falling, or rolling. They can be secured with straps or chains connected to a wall bracket or other fixed surface, or by use of a cylinder stand. " 20. During a tour on 10-17-11 at 1507 hours, the following hazardous condition was observed in the medical gas storage room; 15 large compressed nitrogen gas cylinders were standing upright and secured by a chain connected between a wall bracket behind the cylinders and the copper pipe manifold connecting the tanks to the distribution system. 21. During an interview on 10-17-11 at 1508 hours, staff #A5 confirmed that the nitrogen cylinders should not be secured to the copper manifold with the safety chain.			

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		S1118	The Director of Facilities Management corrected the cited deficiencies that were identified in the hospital cafeteria - fixture shielding - was replaced on 10/19/11 and the nitrogen gas cylinders were secured as required at the time of the finding and an eyewashing device will be installed in the obstetrical unit.The Quality Manager shall address the deficiencies related to expired items and the appropriate storage of tube feedings(materials which contain light sensitive nutrients) with all the areas noted. Auditing shall be conducted through monthly Quality Tracer Team Rounding with results shared directly with the Unit Manager and with the Environment of Care Committee. The information will be reported and reviewed by the Hospital Quality Council.	10/19/2011
S1160	410 IAC 15-1.5-8(d)(1) (d) The equipment requirements are as follows: (1) All equipment shall be in good working order and regularly serviced and maintained. Based on observation and interview, the facility failed to maintain one of two	S1160	The ED room #2 door was repaired and closing securely on 10/19/11. The visual airflow	10/19/2011

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	negative airflow isolation rooms located in the emergency department (ED) in good working order. Findings: 1. During a tour of the ED on 10-18-11 at 1045 hours, in the presence of staff #A5 and #A7, the following condition was observed: The door of airborne isolation room #2 was racked and unable to close completely or latch securely when manually closed. Additionally, the visual indicator for assuring the negative airflow ventilation was operating properly failed to indicate safe operation of the air handling equipment when the door was held closed by staff #A7. Staff #A5 indicated that a work order would be issued for repair of the door and visual airflow indicator. 2. During a followup observation for the ED on 10-19-11 at 0815 hours, in the presence of staff #A7, the room #2 door failed to close completely or latch securely and the airflow indicator failed to confirm safe operation of the negative airflow ventilation if the room was needed for treatment of an airborne isolation patient. 3. On 10-19-11 at 1345 hours, staff #A5 indicated that the ED room #2 door was		indicator confirmed negative ventilation when the door was closed. The Director of Facility Services will monitor quarterly for compliance and the results of the monitoring will be reported to the Hospital Environment of Care Committee. Results will also be reported to and reviewed by the Hospital Quality Council.	

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	repaired and closing securely and that the visual airflow indicator was comfirming negative ventilation when the door was closed.			
S1164	410 IAC 15-1.5-8(d)(2)(B) (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: (B) There shall be evidence of preventive maintenance on all equipment. Based on observation and interview, the facility failed to perform equipment maintenance ensuring a safe working environment for employees in one department. Findings: 1. On 10-17-11 at 1210 hours, staff #A6 was requested to provide documentation of preventive maintenance (pm) for a facility floor scrubber and none was provided prior to exit. 2. During a tour of the environmental services department on 10-18-11 at 1145	S1164	The Director of Facilities Management shall be responsible for assuring that the equipment identified - floor buffer/scrubber - are scheduled for routine inspection and preventative maintenane. As part of the Environment of Care Rounding Team, a sample of equipment shall be selected for evidience of routine inspection and testing. Results of the monthly auditing shall be reported to the Environment of Care Committee and reported and reviewed by the Hospital Quality Council.	10/20/2011

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	hours, (2) Servicemaster 175 rpm floor buffers were observed without evidence of routine inspection and testing. 3. During an interview on 10-18-11 at 1330 hours, staff #A13 confirmed that the floor scrubbers were not currently receiving routine pm.			
S1172	410 IAC 15-1.5-8(e)(1)(A)(B)(C) (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: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on document review, observation, and staff interview, the facility failed to ensure sanitary conditions for Medical/Surgical 4 Unit and the Morgue and failed to ensure the safety of staff with the lack of posting signage indicating hazardous materials in one off site area toured.	S1172	The Director of Environmental Services shall be responsible for assuring that the areas identified as deficient- Medical/Surgical 4 and the Morgue- are regularly cleaned. The Environment of Care Rounding Team shall survey these areas as part of the monthly survey activity with the	10/20/2011

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	Findings included: 1. At 11:00 AM on 10/18/2011, staff member L18 indicated the housekeeping personnel are required to maintain the cleanliness of all Ancillary Areas in the hospital. The staff member indicated ancillary areas are non-patient rooms. The staff member indicated Medical/Surgical 4 and the Morgue are considered Ancillary Areas. However, staff member L18 indicated the housekeeping staff routinely neglects the utility room in the Morgue and this should never happen. 2. Environmental Services Ancillary Areas policy #6004 states, "To describe the steps necessary for cleaning an Ancillary Areas as a training tool for Environmental Services, and to minimize the possibility of cross contamination. The following steps apply to cleaning an Ancillary Area: Set up wet floor sign, Put on PPE, Replenish Paper supplies, Dust all hangings and picture, empty trash, damp wipe interior/exterior of container, replace trash liner, clean and polish sink and mirror, spot clean walls, damp wipe telephones, damp wipe furniture and all horizontal surfaces, mop hard surface floors, vacuum carpet floors, dust vents/lighting weekly." Cleaning		results reported to the Managers of the areas as well as the Environment of Care Committee. A hazardous material sign was placed on the door of the soiled utility room by the Cath Lab manager.	

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	procedure for the morgue requires complete cleaning and disinfecting of the Morgue after the performance of autopsies. 3. At 1:15 PM on 10/17/2011, the Morgue was toured. In the rear of the Morgue was an utility room that contained a floor mounted utility sink. The basin of the utility sink was heavily caked with brownish substance that was about 1 inch thick and the drain was observed clogged with this brown substance. This was observed by staff member L27 and the staff member confirmed the sink needs cleaned. 4. During the tour of the Medical/Surgical 4 Unit at 2:45 PM on 10/18/11, accompanied by staff members L23, L24, and L25, a heavy layer of dust was observed on the tops of a blanket warmer and a near-by wall mounted medication cabinet. This was observed when reaching on top of the equipment to obtain the temperature logs. 5. at 9:50 AM on 10/19/11, while on tour of the off site Cardiac Cath lab in the company of staff member NL, it was observed that: a. the soiled utility room had a large red plastic hazardous waste container present b. there was no hazardous waste symbol/sign on the door of the room			

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	6. interview with staff member NL at 9:50 AM on 10/19/11 confirmed the lack of a hazardous waste sign on the soiled utility door or sign that reads "Soiled Utility"			
S1622	410 IAC 15-1.6-3 (c)(3) (c) Equipment and supplies shall: (3) be inspected, tested, and calibrated at least annually by qualified personnel. Based on observation and interview, the facility failed to perform an annual inspection and calibration for one test instrument in the nuclear medicine department. Findings: 1. During a facility tour on 10-18-11 at 1115 hours, a Ludlum model 177 geiger-mueller counter was observed with a 3-7-1997 date of calibration in the nuclear medicine hot lab. Staff #A6 and #A13 were requested to provide documentation of preventive maintenance and the most recent physicist calibration and none was provided prior to exit. 2. During an interview on 10-18-11 at 1410 hours, staff #A6 indicated that the model 177 geiger-mueller counter lacked recent preventive maintenance or	S1622	The model 177 geiger-mueller counter that was found to lack preventive maintenance or calibration by an approved physicist was permanently removed from service at the hospital on 10/18/11 by the Lead Nuclear Medicine Technician.	10/19/2011

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	calibration by an approved physicist and was removed from service at the facility.			
S1906	410 IAC 15-1.6-6(b) (b) The services shall be under the direction of a physician qualified by training or experience and supervised by a qualified person or persons. Based on document review and interview, the facility failed to ensure that the rehabilitation services were provided under the direction of a physician qualified by training and experience. Findings: 1. On 10-17-11 at 1117 hours, staff #A1 was requested to provide documentation that the rehabilitation services were under the direction of a qualified physician approved by the medical staff and none was provided prior to exit. 2. During an interview on 10-19-11 at 0840 hours, staff #A2 indicated that the inpatient rehabilitation services lacked a medical director.	S1906	A medical director for Rehabilitation Services has been identified and the hospital will be entering into an contractual agreement with the physician. Contracting process will be completed by 3/2012.	11/04/2011