Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	07/31/2012

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T 000	INITIAL COMMENTS This visit was for a State licensure survey. Facility Number: 011118 Survey Date: 7-30-7/31/12 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor QA: claughlin 08/06/12	T 000		
T 026	410 IAC 26-4-1 GOVERNING BODY 410 IAC 26-4-1(c)(3) (c) The governing body shall do the following: (3) Review, at least every six (6) months, reports of management operations, including, but not limited to, the following: (A) Quality assessment and improvement program. (B) Patient services provided. (C) Results attained. (D) Recommendations made. (E) Actions taken. (F) Follow-up. This RULE is not met as evidenced by: Based on document review and interview, the	T 026		

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T 026	Continued From page 1 governing body failed to review every 6 months, 2 services and 4 activities as part of the facility's quality assessment/performance improvement (QAPI) program. Findings: 1. Review of the facility's governing board minutes for the past 2 years indicated the board did not review the services of pharmacy and the contracted heating, ventilation and cooling services, and the activities of discharges, transfers and response to patient emergencies, and medical and medication errors as part of the facility's QAPI program. 2. In interview, on 8-1-12 at 10:35 am, employee #A4 indicated there was no documentation of the above services and activities as part of the facility's QAPI program.	T 026		
T 096	410 IAC 26-6-1 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 26-6-1(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. This RULE is not met as evidenced by:	T 096		

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T 096	Continued From page 2 Based on document review and interview, the facility to include 2 services in its quality assessment/performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include the services of contracted heating, ventilation and cooling, and the pharmacy services. 2. In interview, on 8-1-12 at 10:35 am, employee #A4 indicated there was no documentation of the above services as part of the facility's QAPI program.	T 096		
T 098	410 IAC 26-6-1 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 26-6-1(a)(2) 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. (B) Transfer. (C) Infection control. (D) Response to patient emergencies. This RULE is not met as evidenced by:	T 098		

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T 098	Continued From page 3 Based on document review and interview, the facility failed to include the activities of discharges, transfers and response to patient emergencies in its quality assessment/performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include the activities of discharges, transfers and response to patient emergencies in its quality assessment/performance improvement (QAPI) program. 2. In interview, on 8-1-12 at 10:35 am, employee #A4 indicated there was no documentation of the above activities as part of the facility's QAPI program.	T 098		
T 102	410 IAC 26-6-1 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 26-6-1(a)(4) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (4) Medical and medication errors. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to include the activity of medical and	T 102		

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T 102	Continued From page 4 medication errors in its quality assessment/performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include the activity of medical and medication errors as part of its QAPI program. 2. In interview, on 8-1-12 at 10:35 am, employee #A4 indicated there was no documentation of the above activity as part of the facility's QAPI program.	T 102		
T 164	410 IAC 26-8-3 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-3(a)(1) (a) The clinic must do the following: (1) Develop, implement, and maintain a policy and procedure for the orientation of new employees, contractors, and agency personnel providing direct care and services to patients. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure that new employees who provide direct patient care had documented orientation for 4 of 7 employee files reviewed (1, 4, 5 & 6).	T 164		

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T 164	Continued From page 5 Findings include: 1. Review of facility policy/procedures indicated the following: "Orientation As close to the first day of employment as administratively possible, new employees will receive initial orientation which will include a review of PPIN policies and an explanation of benefits. New employee training will also include a general orientation to PPIN, on the job training and skills testing." This policy/procedure was last reviewed/revised on 10-31-11. 2. Review of the following personal files indicated the following: staff #1 was hired on 12-14-11 and lacked documentation of an orientation. staff #4 was hired on 02-20-12 and lacked documentation of an orientation. staff #5 was hired on 06-25-12 and lacked documentation of an orientation. staff #6 was hired on 03-28-11 and lacked documentation of an orientation. 3. On 07-31-12 at 0840 hours, staff #40 confirmed there was no documentation of orientation for staff #1, 4, 5 & 6.	T 164		
T 168	410 IAC 26-8-3 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-3(b) (b) The clinic shall ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and clinic policy for all health care workers including contract and	T 168		

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T 168	Continued From page 6 agency personnel who provide direct patient care. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice for 2 of 4 physician credential files reviewed. Findings: 1. Review of 4 physician credential files indicated file MD#2 had a CPR competency card with an expiration of 6-30-12 and file MD#3 had a CPR competency card with an expiration date of 1-27-10. 2. In interview, on 8-1-12 at 10:30 am, employee #A4 indicated there was no other documentation of CPR competency for MD#2 and MD#3 and no further documentation was provided prior to exit.	T 168		
T 222	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(e)(1)(A,B,C&D) (e) The clinic must establish a committee to monitor and guide the infection control program in the clinic as follows: (1) The infection control committee must meet at least quarterly. (A) The person directly responsible for management of the infection surveillance,	T 222		

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T 222	Continued From page 7 prevention, and control program as established in subsection (c). (B) The medical director. (C) A representative from the nursing staff (if the clinic employs a licensed nurse). (D) Representatives from other appropriate services within the clinic as needed. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure that infection control committee met quarterly with representation from the person directly responsible for management of the infection surveillance, prevention, and control program, the medical director and a representative from the nursing staff for 7 of 7 infection control meetings. Findings include: 1. Review of the Infection Control committee meeting minutes indicated the following: the 01-19-11 meeting, no infection control person, no medical director and no representative from nursing. the 04-06-11 meeting, no infection control person, no medical director and no representative from nursing. the 07-13-11 meeting, no medical director. the 10-12-11 meeting, no medical director. the 12-06-11 meeting, no infection control person. the 03-07-12 meeting, no infection control person, no medical director and no representative from nursing. the 06-27-12 meeting, no medical director.	T 222		

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T 222	Continued From page 8 2. On 07-30-12 at 1445 hours, staff #40 confirmed that the infection control person, medical director and representative from nursing did not attend the above meetings.	T 222		
T 298	410 IAC 26-13-3 ANESTHESIA AND SURGICAL SERVICES 410 IAC 26-13-3(c) (c) The following equipment and supplies must be available to the procedure and recovery areas when using IV sedation: (1) Defibrillator. (2) Cardiac monitors. (3) Pulse oximeter. (4) Suction equipment. (5) Other supplies and equipment specified by the medical staff. This RULE is not met as evidenced by: Based on interview and observation, the facility failed to ensure that when IV sedation is used on patients, cardiac monitors will be available to facility staff. Findings include: 1. On 07-31-12 at 0955 hours, staff #42 confirmed that the facility uses IV sedation on patients. 2. During the facility tour on 07-31-12 at 0900 hours, no cardiac monitor was observed to be available to facility staff. 3. On 07-31-12 at 1015 hours, staff #40 & 41 confirmed that the facility does not have any cardiac monitors.	T 298		

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T 318	410 IAC 26-16-1 PHARMACEUTICAL SERVICES 410 IAC 26-16-1(1) The clinic must provide drugs and biologicals in a safe and effective manner in accordance with accepted professional practice. The clinic must have the following: (1) A: (A) designated professional person with prescriptive authority; or (B) pharmacist; who is responsible for the control of drug stocks in the clinic. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to designate a professional person with prescriptive authority or pharmacist responsible for control of drug stocks. Findings: 1. Review of facility documents indicated there were none that designated a professional person with prescriptive authority or pharmacist responsible for control of drug stocks. 2. In interview, on 8-1-12 at 10:25 am, employee #A4 indicated there was no documentation of a professional person with prescriptive authority or pharmacist responsible for control of drug stocks and no other documentation was provided prior to exit.	T 318		

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T 404	Continued From page 10	T 404		
T 404	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(2) The condition of the physical plant and the overall clinic environment must be developed and maintained in such a manner that the safety and well-being of patients is assured as follows: (2) No condition may be created or maintained that may result in a hazard to: (A) patients; (B) authorized visitors; or (C) employees. This RULE is not met as evidenced by: Based on observation, the facility created 1 condition that may have resulted in a hazard to patients, visitors or employees. Findings: 1. On 7-31-12 at 10:05 am, in the presence of employee #A3, it was observed in the medication room there was 1 small oxygen tank standing upright on the floor that was not chained or secured. If the tank was knocked over and broke the head off the compressed cylinder, it could cause harm to people and/or property.	T 404		
T 408	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(3)(B) The condition of the physical plant and the overall	T 408		

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T 408	Continued From page 11 clinic environment must be developed and maintained in such a manner that the safety and well-being of patients is assured as follows: (B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with one (1) of the following: (i) Acceptable standards of practice. (ii) The manufacturer ' s recommended maintenance schedule. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to document a maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule for 2 pieces of equipment. Findings: 1. Review of preventive maintenance (PM) documents indicated there were none for a wheelchair and the nurse call emergency system (telephone intercom). 2. In interview, on 8-1-12 at 10:15 am, employee #A4 indicated there was no PM documentation for the above 2 pieces of equipment and no documentation was provided prior to exit.	T 408		
T 420	410 IAC 26-17-4 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY	T 420		

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T 420	Continued From page 12 410 IAC 26-17-4(4) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (4) Defibrillators must be discharged at least in accordance with manufacturers ' recommendations, and a discharge log with initialed entries must be maintained. This RULE is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure that the defibrillator be discharged in accordance of the manufacturer's recommendations and a discharge log with initialed entries for 1 of 1 AED. Findings include: 1. Review of the Cardiac Science AED manufacturer ' s recommendations indicated the following; " Daily Maintenance Check the Status Indicator to ensure that it is GREEN. " 2. During the facility tour on 07-31-12 at 1025 hours, a Cardiac Science AED was observed in the Recovery area. 3. On 07-31-12 at 1025 hours, staff #40 & 41 confirmed that the facility did not maintain a log that indicated that daily checks of the AED were being performed.	T 420		
T 438	410 IAC 26-17-6 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY	T 438		

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T 438	Continued From page 13 410 IAC 26-17-6(a)(6) (a) A safety management program must include, but not be limited to, the following: (6) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with the following: (A) Clinic policy. (B) State and local regulations. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to have written evidence of regular inspection and approval by a state or local fire control agency. Findings: 1. Review of facility documents indicated there were none for regular inspection and approval by a state or local fire control agency (or annual request of same). 2. In interview, on 8-1-12, employee #A4 indicated there was no documentation of regular inspection and approval by a state or local fire control agency (or annual request of same) and no other documentation was provided prior to exit.	T 438		