STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151327
MULTIPLE CONSTRUCTION

A. BUILDING
B. WING

DATE SURVEY COMPLETED
09/07/2016

NAME OF PROVIDER OR SUPPLIER
SULLIVAN COUNTY COMMUNITY HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE
2200 N SECTION ST
SULLIVAN, IN 47882

PREFIX TAG ID

PREFIX TAG ID

S 0000
Bldg. 00

This visit was for a Hospital State licensure survey.

Facility Number: 005013

Dates: 9/6/16 to 9/7/16

QA: 11/1/16 jlh

PREFIX TAG ID

PREFIX TAG ID

S 0594
Bldg. 00

410 IAC 15-1.5-2 INFECTION CONTROL

410 IAC 15-1.5-2(f)(3)(D)(ii)

(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:

(ii) Universal precautions, including infectious waste management.

Based on document review, observation and interview, the facility failed to ensure storage of infectious waste in a secure area in 5 of 9 areas toured (Intensive Care Unit [ICU], Medical Surgical,

All of the soiled utility room doors are now locked. Policy #245.63/530.09, Clean Linen Carts/Clean Linen Distribution/Soiled Linen Collection/Safety Procedures, has been reviewed by nursing staff. Nursing staff has been

10/03/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

________________________________________________________________________

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

________________________________________________________________________

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
## Emergency Department [ED], Outpatient Surgery, and Obstetrics [OB])

Findings:

1. **Policy: 245.18, Medical Waste Management Plan, revised/reviewed on 3/16 indicated on page 4, waste containers are stored in a designated secured area that allows no access to the public and in a manner that is not conducive to microbial growth.**

2. During tour of units ED, Outpatient Surgery, ICU, OB and Medical Surgical on 9/7/16 at approximately 1300, 1330, 1400, 1430 and 1500 hours, accompanied by staff N1 (Chief Nursing Officer), the soiled utility rooms containing infectious waste were observed unlocked/unsecured.

3. While on tour of facility on 9/7/16 at approximately 1530 hours, staff N1 confirmed soiled utility rooms in the ED, Outpatient Surgery, ICU, OB and Medical Surgical were not locked and accessible by staff without secured entry.

4. On 9/7/16 at approximately 1600 hours, staff N2 (Infection Control Preventionist) confirmed soiled utility rooms observed on tour were unlocked and contained infectious waste. Staff N2 re-educated on the necessity for keeping the Soiled Linen Doors locked. The Infection Control Preventionist will be responsible for monitoring the doors during her daily/monthly rounds.
confirmed facility was not following Policy 245.18, Medical Waste Management Plan.

<table>
<thead>
<tr>
<th>S 0606</th>
<th>410 IAC 15-1.5-2 INFECTION CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bldg. 00</td>
<td>410 IAC 15-1.5-2(f)(3)(D)(viii)</td>
</tr>
</tbody>
</table>

(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 document review and interview, the infection control/employee health nurse failed to ensure that the employee health program followed policies for communicable disease for 1 of 1 employees who transitioned into a healthcare worker position (P1).

Findings:

<table>
<thead>
<tr>
<th>S 0606</th>
<th>The employee identified in this citation has been tested for communicable disease as required by the Employee Health program. (Copy of the lab results is attached.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>09/08/2016</td>
</tr>
</tbody>
</table>

A noted has been added to HR's internal process so that when an employee transfers into a healthcare worker position, the Employee Health policies for...
1. Review of policy 250.03/245.141
   Department: Employee Health Program indicated the following:
   a. Documentation of measles, mumps, rubella (MMR) vaccination or lab confirmation of immunity will be required within ten (10) days of hire date.
   b. Also, evidence of immunity for varicella includes 2 doses of varicella vaccine, physician diagnosis, or lab confirmation of immunity.
   c. All departments require MMR/Varicella documentation/titre immunity with the exception of Volunteers and Fitness Center (only require Rubella titre and Hepatitis B series status).
   d. The employee health nurse will review the results and notify the prospective employee of any follow-up that is needed.
   e. Employee health records will be maintained by the employee health nurse.
   f. Reviewed 6/14

2. Review of the personnel files indicated P1 was newly employed as a pharmacy technician on 1/12/15. The personnel file lacked documentation of confirmation for immunity to Rubeola or Varicella.

3. On 9/7/16 at 1:15pm, A8, Infection Control/Employee Health, indicated P1 communicable disease are followed. This process will be monitored by the HR Director and EH nurse on a monthly basis.
transitioned into the pharmacy tech position in 2015 after having been a volunteer/employee of the fitness center. A8 indicated the employee should have had confirmation of immunization prior to moving into the pharmacy technician position and verified the personnel file lacked the confirmation documentation.

410 IAC 15-1.5-4 MEDICAL RECORD SERVICES
410 IAC 15-1.5-4(f)(5)

(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:

(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.

Based on record review and staff interview, the hospital failed to complete all documentation for evidence of informed consent for two of twenty units of blood (units 7a and 7b).

Finding(s) included:

1. The Blood/Blood Products Transfusion policy, Policy # 200.101, reviewed 5/15, read:

All blood transfusion documentation, including the Informed Consent document, will continue to be monitored by nursing through their monthly QA process. Incidents of non-compliance will be addressed immediately with the staff person involved to ensure that no further incidents of incomplete documentation will be identified. The Director of Med/Surg will be responsible for the monthly QA monitoring process.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151327

DATE SURVEY COMPLETED: 09/07/2016

NAME OF PROVIDER OR SUPPLIER: SULLIVAN COUNTY COMMUNITY HOSPITAL
STREET ADDRESS, CITY, STATE, ZIP CODE: 2200 N SECTION ST, SULLIVAN, IN 47882

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>S 1024</td>
<td>410 IAC 15-1.5-7</td>
<td>PHARMACEUTICAL SERVICES</td>
<td>410 IAC 15-1.5-7 (d)(2)(C)</td>
</tr>
</tbody>
</table>

"Check doctor's order and obtain written Consent for Transfusion of Blood and Blood and Blood Products."

2. One patient, receiving two blood units, had an incomplete consent form including:

-Units 7a and 7b, were each administered on 8/08/16 at 10:35 a.m. and 1:15 p.m. respectively. The consent for each of these units was missing the date signed by the patient.

3. On 9/06/16 at 12:55 p.m., staff member #1 acknowledged the above-listed patient had received 2 blood units without benefit of a completed consent form.

(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
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</td>
<td>S 1024</td>
<td>All pharmacy staff have been required to review policy PSI VIII-A(I), Infection Control/Safety Procedures - Medication Vial/Ampoule Guidelines, and PSI VI-P, Medication Distribution - Compounding of Sterile Preparations, and complete a competency exam. All reconstituted and mixed medications will be visually examined prior to distribution for patient use to ensure that an expiration date of &quot;use by&quot; date is on the label. The Director of Pharmacy will be responsible for ensuring this is monitored and completed on a daily basis.</td>
<td>09/09/2016</td>
</tr>
</tbody>
</table>

Findings:

1. Review of the policy titled Infection Control/Safety Procedures - Medication Vial/Ampoule Guidelines indicated the following:
   a. The pharmacy is expected to provide pharmaceutical products for patient use, prepared and distributed under the most stringent infection control standards.
   b. The proper handling of single dose vials and ampoules and multiple dose vials of medications is important to reducing the infection risk.
   c. Single dose containers opened in "ISO Class 5 Air Quality" (in a certified "hood") can be used for up to six hours. 
   d. Revision Date: September 2014

2. Review of the policy titled Medication Distribution - Compounding of Sterile
Preparations indicated the following:

a. The Department of Pharmacy is responsible for the compounding of sterile preparations intended for patient administration. The provision of this service is according to all standards relating to aseptic manipulation skills and is under the direct supervision of a registered pharmacist at all times.

b. Labeling - All CSP (compounded sterile products) prepared by the pharmacy shall be labeled with the inclusion of the information as follows: (not all inclusive) Beyond use date (use by date and use by time).

c. The label shall be time-stamped (or the preparation time written on the label) indicating the use by date and time...

d. The beyond use date and time must be written or typed on the label.

e. The pharmacy shall be responsible for proper handling and packaging of compounded preparations...in order to maintain integrity, efficacy, stability and, where applicable, sterility of preparations

f. Review Date: June 2015

3. Review of the policy titled Inventory Control - Expired and Other Unusable Medications indicated the following:

a. Expired medications and other unusable medications are stored in a manner that prevents their use and distribution and ensures that they are
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>disposed of safely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b. Medications are removed from the medication storage areas if they are: (not all inclusive) Expired (outdated). Mislabeled, Defective (e.g., improperly packaged, improperly stored,…and medications whose integrity, effectiveness and stability are questionable).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e. Storage areas for expired and unusable medications must be separated from active stock.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>d. Review Date: June 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. On 9/7/16 at 3:45pm, during facility tour, in the hospital pharmacy, in the presence of A10, Maintenance, and S1, pharmacist, inside the medication storage refrigerator, among medications/drugs was an opened vial with a manufacturer label for 500mg/vial Vancomycin Hydrochloride injection, powder for solution. The vial contained approximately 5cc of a clear liquid/solution and lacked documentation of a date the solution was prepared or would expire. The manufacturer expiration date (of the powder) indicated Ex 9/18. Also observed in the refrigerator were 2 small (150ml) infusion solution bags each labeled with a patient name and information that indicated the solution/bags contained 1 gram vancomycin/150 ml 0.9% NaCl</td>
</tr>
</tbody>
</table>
(Sodium Chloride). The label indicated Due Date: 8/28/16, Exp. _____ (area was blank). No other expiration or use by date was noted on the labels.

5. Review of Vancomycin Hydrochloride manufacturer product information indicated the following:
   a. Directions for Proper Use: The container closure may be penetrated only one time after reconstitution...
   b. Once this container closure has been punctured, withdrawal of the contents should be completed without delay.

6. On 9/7/16 at 3:45pm, S1 indicated that reconstituted and mixed medications could be refrigerated for up to 14 days if not expired prior to that date. S1 also indicated that all opened vials (reconstituted or not) and all mixed medications should be labeled with an expiration/use by date and that neither the vancomycin vial nor the 2 infusion solution bags contained documentation of an expiration or use by date. S1 indicated the medications/drugs were not useable as labeled/found, should have been detected as unusable and been removed from general inventory for destruction.
| X1 | PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 151327 |
| X2 | MULTIPLE CONSTRUCTION | A. BUILDING 00 | B. WING |
| X3 | DATE SURVEY COMPLETED | 09/07/2016 |

**NAME OF PROVIDER OR SUPPLIER**

SULLIVAN COUNTY COMMUNITY HOSPITAL

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2200 N SECTION ST
SULLIVAN, IN 47882

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>

State Form

Event ID: TFZY11
Facility ID: 005013
If continuation sheet Page 11 of 11