STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151304	A. BUILDING 00 B. WING	07/24/2012

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

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C0000	This visit was for a recertification survey. Facility Number: 005082 Survey Date: 7-23/24-12 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor Cleone Peterson Medical Surveyor QA: claughlin 07/31/12	C0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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C0204	485.618(b)(2) EQUIPMENT AND SUPPLIES [The items available must include the following:] Equipment and supplies commonly used in life saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters. Based on document review and interview, it could not be determined if a discharge log had followed hospital policy for 1 of 1 defibrillators Findings: 1. Review of hospital policy Section Number: 904, entitled Emergency (Crash) Carts, revised 7/2011, indicated the staff members assigned to the departments which house the emergency carts are responsible for performing readiness assessments (crash cart checks) per departmental policy. 2. Review of a document entitled Crash Cart Drug and Supply List 2012, located in the Cardiac Rehab area, indicated there was a checkmark for the date 7-23-12, for a line entitled Monitor with electrodes/Defib pads/ ped and adult. It was vague as to the meaning of the word	C0204	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.The Crash Cart/Supply List Log has been revised to include: a. Departmental employee initials/signaturesb. Date the Crash Cart and Supply List was checkedc. Defibrillator discharged checkedd. Defibrillator Electrode Gel available and checkede. Defibrillator monitor paper available and checkedf. Defibrillator pads available for both adult and pediatric useg. Defibrillator Electrodes/Cables available for both adult and pediatric useh. Defibrillator Operation Manual attached to crash cart2. How are you going to prevent the deficiency from recurring in the future?The Crash Cart/Supply List Log will be monitored on a monthly basis for accuracy and completion, including employee initials/signatures.3. Who is going to be responsible for numbers 1	08/13/2012

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	"Monitor". Also, there was no signature or initials as to who had made the checkmark. Thus, it could not be determined if the defibrillator had been tested for performing readiness assessment and by whom. 3. In interview, on 7-23-12 at 11:10 am, hospital staff indicated there was no other documentation of testing of the defibrillator and no other documentation was provided prior to exit.		and 2 above; i.e., director, supervisor, etc.?The Director of Cardiology Services will be responsible for tracking the Crash Cart/Supply List Log and for maintaining a detailed log of all items included as part of the crash cart, medications, and supplies.4. By what date are you going to have the deficiency corrected? The revised Crash Cart/Supply List Log will be implemented on 08/13/12.a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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C0222	485.623(b)(1) MAINTENANCE The CAH has housekeeping and preventive maintenance programs to ensure that-- all essential mechanical, electrical, and patient care equipment is maintained in safe operating condition; Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 3 pieces of equipment. Findings: 1. Review of documentation of PM on a portable x-ray machine indicated the most recent PM occurred on 12-8-10. 2. In interview, on 7-24-12 at 11:20 am, employee #A4 indicated there was no current documentation and no other documentation was provided prior to exit. 3. Review of documentation of PM on a mammography scanner indicated the most recent PM occurred on 4-23-09. 4. In interview, on 7-24-12 at 11:20 am, employee #A4 indicated there was no current documentation and no other documentation was provided prior to exit. 5. Review of documentation of PM on a sleep study machine indicated all patient	C0222	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.Preventive Maintenance (PM) on the portable x-ray machine has been obtained by RPS Imaging. PM for proper operation of equipment was checked and approved.PM on the mammography scanner will be conducted by RPS Imaging on 08/15/12.PM on the sleep center Analysis2 Computer, Analysis2 Monitor, cameras, Collector3 Computer, and Collector3 Monitor have been provided and approved by Hancock Regional Health as of 08/09/12. The Pro-Tech PTAF-2 Pressure Transducer Airflow Sensor, Sandman Digital 32+ Amplifier, Respironics CPAP Machine, and Sandman Impedance Meter will be checked by Diversified on 08/15/12.2. How are you going to prevent the deficiency from recurring in the future?The Preventive Maintenance on all equipment will be scheduled on an annual basis with a reminder being placed on outlook calendar for the following year. The Preventive	08/15/2012

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	related equipment in the Rush-Hancock Sleep Disorders Center has been checked as of 5-31-12. The report did not indicate which specific equipment was checked and what specific checks were done. 6. In interview, on 7-24-12 at 11:15 am, employee #A4 indicated there was no documentation of which specific equipment was checked and what specific checks were done and no other documentation was provided prior to exit.		Maintenance will include documented descriptive details. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The Director of Imaging will be responsible for the Preventive Maintenance on the portable x-ray and mammography scanner.The Director of Physician Practices will be responsible for the Preventive Maintenance on the sleep study equipment.4. By what date are you going to have the deficiency corrected? The PM on the portable x-ray machine has been correct on 08/01/2012.The PM on the mammography scanner will be corrected on 08/15/12.The PM on the sleep study has included which equipment was inspected. This has been corrected on 08/09/12 for the computer equipment. The CPAP machine, transducer, amplifier, and meter for the sleep study will be corrected on 08/15/12.a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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C0271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. Based on transfusion record review, training record review, and staff interview, the facility failed to have documented training on transfusion administration as required consistent with applicable State law for one of five registered nurses reviewed who initiated one of seven transfusion records reviewed. Findings included: 1. On 7/24/12 between 12:00 p.m. and 2:00 p.m. during transfusion record review, transfusions T#1 to T#7 were reviewed and found to have been initiated by staff persons SP#16 through SP#20. 2. On 7/24/12 between 2:00 p.m. and 3:00 p.m. training records for transfusion administration were requested for the above nurses and were obtained for all except SP#20. 3. In interview on 7/24/12 at 2:30 p.m., staff person #3 stated there was no documented training for SP#20 who initiated T# 2 without required special training consistent with applicable State law.	C0271	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.The blood transfusion training competency record has been completed.2. How are you going to prevent the deficiency from recurring in the future?The blood transfusion training competency record will be completed during the orientation process of all new nurses.3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The Director of Inpatient Services will be responsible for tracking the blood transfusion training competency record for new nurses.4. By what date are you going to have the deficiency corrected? This deficiency has been corrected on 08/10/12.a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	08/10/2012

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C0280	485.635(a)(4) PATIENT CARE POLICIES These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. Based on document review and interview, the facility failed to ensure that the patient care policies were reviewed at least annually by at least one or more doctors of medicine or osteopathy of the medical staff, one or more nurse practitioners, who are members of the CAH Medical Staff, and at least one member who is not a member of the CAH staff. Findings include: 1. Review of the Patient Care Policy Manual and facility documentation lacked documentation that a physician or nurse practitioner non medical staff member reviewed the Patient Care Policy Manual on the last annual review. 2. On 07-24-12 at 1130 hours staff #40 confirmed that the Patient Care Policy Manual is reviewed annually by members of the CAH Medical Staff and do not have documentation that at least 1 physician or nurse practitioner who is not a member of the CAH Staff reviewed the patient care policies.	C0280	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Will provide documentation that a physician or nurse practitioner non-medical staff member reviewed the Patient Care Policy Manual on an annual basis. This individual is not a member of the hospital's medical staff. 2. How are you going to prevent the deficiency from recurring in the future? We will meet annually with the non-medical staff member for the Patient Care Policy review. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The Vice President of Nursing will be responsible for annual review of the Patient Care Policy Manual. 4. By what date are you going to have the deficiency corrected? The deficiency will be	08/23/2012

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			corrected by 08/23/12. a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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C0337	485.641(b)(1) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that- all patient care services and other services affecting patient health and safety are evaluated. Based on document review and interview, the hospital failed to include monitors and standards for 1 service directly-provided by the hospital and 1 service provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include monitors and standards for the directly-provided rehabilitation services. 2. In interview on 7-24-12 at 4:00 pm, employee #A2 indicated there was no documentation for directly-provided rehabilitation services and none was provided prior to exit. 3. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted telepsych	C0337	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.The Rehabilitation Department has added four new Quality Improvement Monitors; 1. Measurable/relevant outcome goals during the initial evaluation for continued rehabilitation treatments per non-contracted staff members. 2. Measurable/relevant outcome goals during the initial evaluation for continued rehabilitation treatments per contracted staff members. 3. Accurate billing to reflect provided service per non-contracted staff members. 4. Accurate billing to reflect provided service per contracted staff members. This will allow for monitoring to take place on both non-contracted and contracted staff members within the Rehabilitation Department.The Social Services Department will add a Quality Improvement Monitor to measure the contracted telepsych service	08/01/2012

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	service. 4. In interview on 7-24-12 at 3:45 pm, employee #A2 indicated there was no documentation for the telepsych service and none was provided prior to exit.		volumes as it relates to monthly usage.2. How are you going to prevent the deficiency from recurring in the future?The new quality improvement monitors for rehabilitation and telepsych will have the data collected and recorded on a monthly basis. The monitors will be presented and discussed during the quarterly Quality Improvement Meetings.3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The Director of Rehabilitation Services will be responsible for rehabilitation monitors.The Director of Social Services will be responsible for the telepsych monitor.4. By what date are you going to have the deficiency corrected? This deficiency has been corrected as of 08/01/12. a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey.b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S0266	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(4) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (4) Review the bylaws at least triennially. Based on review of documents and interview, the governing board failed to review their bylaws at least triennially. Findings: 1. Review of the governing board by-laws indicated it was last reviewed by the governing board on 5-27-08. 2. In interview, on 7-23-12 at 2:50 pm, employee #A7 indicated there was not a more recent review and none was provided prior to exit.	S0266	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.The By-Laws have been presented to the Board of Trustees. There were reviewed and have now been approved. A copy of the signature page was given to the surveyor on July 24, 2012, by the Executive Secretary. 2. How are you going to prevent the deficiency from recurring in the future? The review of the by-laws as required will be placed on the calendaring system maintained by the Hospital. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The Executive Secretary. 4. By what date are you going to have the deficiency corrected? The deficiency was corrected at the Board of Trustees meeting held on July 23, 2012. a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum	07/24/2012

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			correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S0270	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up. Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 1 directly-provided service and 1 contracted service. Findings: 1. Review of the governing board minutes for calendar year 2011 indicated they did not include review of reports for the directly-provided rehabilitation services. 2. In interview on 7-24-12 at 4:00 pm, employee #A2 indicated no report for the directly-provided rehabilitation services was reviewed by the governing board in calendar year 2011 and no further documentation was provided prior to exit.	S0270	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.We will continue reporting quarterly and will include the rehabilitation and telepsych services quality measures of both contracted and non-contracted employees. 2. How are you going to prevent the deficiency from recurring in the future?It will be incorporated into the quality measures presented each quarter. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?VP of Nursing/Risk & Compliance and the Lead Quality & Safety Program Liaison. 4. By what date are you going to have the deficiency corrected? The report will be presented at the Board of Trustees meeting to be held August 27, 2012. a. You must provide a specific date the	08/27/2012

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	3. Review of the governing board minutes for calendar year 2011 indicated they did not include review of reports for the contracted telepsych services. 4. In interview on 7-24-12 at 3:45 pm, employee #A2 indicated no report for the contracted telepsych service was reviewed by the governing board in calendar year 2011 and no further documentation was provided prior to exit.		deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S0406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include monitors and standards for 1 service directly-provided by the hospital and 1 service provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include monitors and standards for the directly-provided rehabilitation services. 2. In interview on 7-24-12 at 4:00 pm, employee #A2 indicated there was no documentation for directly-provided rehabilitation services and none was provided prior to exit.	S0406	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.The Rehabilitation Department has added four new Quality Improvement Monitors; 1. Measurable/relevant outcome goals during the initial evaluation for continued rehabilitation treatments per non-contracted staff members. 2. Measurable/relevant outcome goals during the initial evaluation for continued rehabilitation treatments per contracted staff members. 3. Accurate billing to reflect provided service per non-contracted staff members. 4. Accurate billing to reflect provided service per contracted staff members. This will allow for monitoring to take place on both non-contracted and contracted staff members within the	08/01/2012

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	151304	A. BUILDING 00 B. WING	07/24/2012

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	3. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted telepsych service. 4. In interview on 7-24-12 at 3:45 pm, employee #A2 indicated there was no documentation for the telepsych service and none was provided prior to exit.		Rehabilitation Department.The Social Services Department will add a Quality Improvement Monitor to measure the contracted telepsych service volumes as it relates to monthly usage.2. How are you going to prevent the deficiency from recurring in the future?The new quality improvement monitors for rehabilitation and telepsych will have the data collected and recorded on a monthly basis. The monitors will be presented and discussed during the quarterly Quality Improvement Meetings.3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The Director of Rehabilitation Services will be responsible for rehabilitation monitors.The Director of Social Services will be responsible for the telepsych monitor.4. By what date are you going to have the deficiency corrected? This deficiency has been corrected as of 08/01/12. a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey.b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S0554	410 IAC 15-1.5-2 INFECTION CONTROL 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. Based on observation, the hospital created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors. Findings: 1. On 7-23-12 at 11:20 am in the presence of employees #A4 and #A5, it was observed in the housekeeping storage area, on a shelf, there were 2 rolls of handtowels and 10 packages of handtowels not stored and/or completely protected by wrapping. 2. By being unprotected, the items were subject to contamination from dirt and other soilage.	S0554	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A meeting was held between the Facility and Environmental Services Director and the Environmental Services Department on July 24 th 2012 addressing the housekeeping storage area where items were inappropriately stored. The staff was instructed to not take paper products out of their boxes and store them unprotected. The deficiency was corrected on July 24 th 2012. 2. How are you going to prevent the deficiency from recurring in the future? The deficiency will be periodically brought up during future Environmental Services staff meetings to prevent a reoccurrence. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The Facility and Environmental Services Director will be responsible for numbers 1 and 2 above.	07/25/2012

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			4. By what date are you going to have the deficiency corrected? This deficiency was corrected on July 24 th 2012. a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S0570	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.			
	Based on document review and interview, the facility failed to ensure the infection control committee followed its policy/procedure for meeting quarterly with designated members. Findings include: 1. Review of policy/procedure Introduction to Infection Control Program indicated the following: "Members of Infection Control Team Infection Control Committee meets	S0570	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Infection Control Program Policy has been revised to state, if a committee member is going to be absent from the meeting, they will be required to send a designee as their representative. 2. How are you going to prevent the deficiency from	08/13/2012

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	quarterly to examine all areas of infection control. Committee members are Laboratory Pathologist, IC Coordinator, Laboratory Director/IC Officer, Quality Improvement Director, Chief Nursing Officer, Pharmacist, Housekeeping Supervisor, Employee Health Coordinator and Dietary Director." This policy/procedure was last reviewed/revised on 01-12-12. 2. Review of the Infection Control Committee minutes indicated the following: at the 01-12-12 meeting the Pharmacist was absent. at the 04-12-12 meeting the Laboratory Pathologist and Pharmacist were absent. at the 07-12-12 meeting the Laboratory Pathologist, Chief Nursing Officer and Pharmacist were absent. 3. On 07-24-12 at 0955 hours, staff #42 confirmed that the above infection control members were not present at the Infection Control Committee meetings.		recurring in the future? It is mandatory that all committee members be represented in each of the quarterly meetings. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? Director of Infection Control will be responsible to assure that all departments are represented at each meeting. 4. By what date are you going to have the deficiency corrected? This deficiency will be corrected on 08/13/12 with the policy revision and the committee members notified of the attendance requirement. a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S0952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved 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 transfusion record review, training record review and staff interview, the facility failed to have documented training on transfusion administration as required for one of five registered nurses reviewed who initiated one of seven transfusion records reviewed. Findings included: 1. On 7/24/12 between 12:00 p.m. and 2:00 p.m. during transfusion record review, transfusions T#1 to T#7 were reviewed and found to have been initiated by staff persons SP#16 through SP#20. 2. On 7/24/12 between 2:00 p.m. and 3:00 p.m. training records for transfusion administration were requested for the above nurses and were obtained for all except SP#20. 3. In interview on 7/24/12 at 2:30 p.m., SP#3 stated there was no documented training for SP#20 on the administration	S0952	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.The blood transfusion training competency record has been completed.2. How are you going to prevent the deficiency from recurring in the future?The blood transfusion training competency record will be completed during the orientation process of all new nurses.3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The Director of Inpatient Services will be responsible for tracking the blood transfusion training competency record for new nurses.4. By what date are you going to have the deficiency corrected? This deficiency has been corrected on 08/10/12.a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time	08/10/2012

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	of transfusions.		allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S1118	410 IAC 15-1.5-8 PHYSICAL PLANT 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, the hospital created a condition which resulted in a hazard to patients, public or employees in 2 instances. Findings: 1. On 7-24-12 at 11:40 am, in the presence of employees #A4 and #A5, it was observed in the 3rd floor Administration hallway, there 2 alcohol hand-based sanitizers (ABHS) affixed to the wall. It was also observed the floor was carpeted and the area was not sprinklered. 2. Lack of a sprinkler system in the area posed a fire hazard.	S1118	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. All alcohol hand-based sanitizers (ABHS) were removed from the carpeted, unsprinklered Administrative hallways. Due to the cost of adding a sprinkler system in a non-patient area, it was decided to remove the ABHS. 2. How are you going to prevent the deficiency from recurring in the future? No longer allow ABHS in this area. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? Director of Physical Plant will be responsible to assure no	07/25/2012

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			placement of ABHS in carpeted, unsprinklered areas. 4. By what date are you going to have the deficiency corrected? This deficiency has been corrected as of 07/25/12. a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S1164	410 IAC 15-1.5-8 PHYSICAL PLANT 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 document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 3 pieces of equipment. Findings: 1. Review of documentation of PM on a portable x-ray machine indicated the most recent PM occurred on 12-8-10. 2. In interview on 7-24-12 at 11:20 am, employee #A4 indicated there was no current documentation and no other documentation was provided prior to exit. 3. Review of documentation of PM on a mammography scanner indicated the most recent PM occurred on 4-23-09. 4. In interview on 7-24-12 at 11:20 am, employee #A4 indicated there was no	S1164	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.Preventive Maintenance (PM) on the portable x-ray machine has been obtained by RPS Imaging. PM for proper operation of equipment was checked and approved.PM on the mammography scanner will be conducted by RPS Imaging on 08/15/12.PM on the sleep center Analysis2 Computer, Analysis2 Monitor, cameras, Collector3 Computer, and Collector3 Monitor have been provided and approved by Hancock Regional Health as of 08/09/12. The Pro-Tech PTAF-2 Pressure Transducer Airflow Sensor, Sandman Digital 32+ Amplifier, Respironics CPAP Machine, and Sandman Impedance Meter will be checked by Diversified on 08/15/12.2. How are you going to prevent the	08/15/2012

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	current documentation and no other documentation was provided prior to exit. 5. Review of documentation of PM on a sleep study machine indicated all patient related equipment in the Rush-Hancock Sleep Disorders Center has been checked as of 5-31-12. The report was vague because it did not indicate which specific equipment was checked and what specific checks were done. 6. In interview on 7-24-12 at 11:15 am, employee #A4 indicated there was no documentation of which specific equipment was checked and what specific checks were done and no other documentation was provided prior to exit.		deficiency from recurring in the future?The Preventive Maintenance on all equipment will be scheduled on an annual basis with a reminder being placed on outlook calendar for the following year. The Preventive Maintenance will include documented descriptive details. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The Director of Imaging will be responsible for the Preventive Maintenance on the portable x-ray and mammography scanner.The Director of Physician Practices will be responsible for the Preventive Maintenance on the sleep study equipment.4. By what date are you going to have the deficiency corrected? The PM on the portable x-ray machine has been correct on 08/01/2012.The PM on the mammography scanner will be corrected on 08/15/12.The PM on the sleep study has included which equipment was inspected. This has been corrected on 08/09/12 for the computer equipment. The CPAP machine, transducer, amplifier, and meter for the sleep study will be corrected on 08/15/12.a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the	

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			nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	

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S1168	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on document review and interview, it could not be determined if a discharge log had followed hospital policy for 1 of 1 defibrillators Findings: 1. Review of hospital policy Section Number: 904, entitled Emergency (Crash) Carts, revised 7/2011, indicated the staff members assigned to the departments which house the emergency carts are responsible for performing readiness assessments (crash cart checks) per departmental policy. 2. Review of a document entitled Crash Cart Drug and Supply List 2012, located in the Cardiac Rehab area, indicated there was a checkmark for the date 7-23-12, for a line entitled Monitor with electrodes/Defib pads/ ped and adult. It was vague as to the meaning of the word "Monitor". Also, there was no signature	S1168	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.The Crash Cart/Supply List Log has been revised to include: a. Departmental employee initials/signaturesb. Date the Crash Cart and Supply List was checkedc. Defibrillator discharged checkedd. Defibrillator Electrode Gel available and checkede. Defibrillator monitor paper available and checkedf. Defibrillator pads available for both adult and pediatric useg. Defibrillator Electrodes/Cables available for both adult and pediatric useh. Defibrillator Operation Manual attached to crash cart2. How are you going to prevent the deficiency from recurring in the future?The Crash Cart/Supply List Log will be monitored on a monthly basis for accuracy and completion, including employee initials/signatures.3. Who is going to be responsible for numbers 1 and 2 above; i.e., director,	08/13/2012

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	or initials as to who had made the checkmark. Thus, it could not be determined if the defibrillator had been tested for performing readiness assessment and by whom. 3. In interview on 7-23-12 at 11:10 am, hospital staff indicated there was no other documentation of testing of the defibrillator and no other documentation was provided prior to exit.		supervisor, etc.?The Director of Cardiology Services will be responsible for tracking the Crash Cart/Supply List Log and for maintaining a detailed log of all items included as part of the crash cart, medications, and supplies.4. By what date are you going to have the deficiency corrected? The revised Crash Cart/Supply List Log will be implemented on 08/13/12.a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.	