

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151327	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2015
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N SECTION ST SULLIVAN, IN 47882
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005013</p> <p>Dates: 1/5/15 to 1/6/15</p> <p>Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Ziegler, MT MS Medical Surveyor III</p> <p>QA: cloughlin 02/05/15</p>	S000000		
S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and</p>			

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

TITLE

(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.

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S000420	<p>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:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital quality assessment performance improvement program (QAPI) failed to include 3 contracted services (Biomedical engineering, biohazard waste hauler, and tele-psychology) in its evaluations.</p> <p>Findings:</p> <p>1. Review of QAPI meeting minutes dated 1/6/14, 4/7/14, 7/10/14 and 11/11/14 lacked evidence of quality monitoring for the following 3 contracted services: Biomedical engineering, biohazard waste hauler, and tele-psychology.</p> <p>2. In interview on 1/16/15 at 3:10pm, A3 confirmed the above services had not been included in past QAPI evaluations.</p> <p>410 IAC 15-1.4-2.2</p>	S000406	<p>Quality monitoring has, in fact, been completed for 2014 for biomedical engineering and the biohazard waste hauler. However, these reports were taken to the Safety Committee instead of the Performance Improvement Committee. There were no quality monitoring reports available for the telemental health service. All 3 contract services noted have been added to the PI report tickler sheet. The QI Director will be responsible for monitoring to ensure that the reports are submitted to the PI Committee on a quarterly basis.</p>	02/20/2015	

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	<p>QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the hospital:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention.</p>			

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	<p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p>			

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	<p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of</p>			

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	<p>which occurs while the patient is being cared for in the hospital.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a</p>			

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S000554	<p>physician, nurse, pharmacist, or other licensed healthcare provider. (ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on the grounds of the hospital. (iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital. Based on document review and interview, the hospital quality assessment and performance improvement (QAPI) program failed to include reportable events.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of QAPI meeting minutes dated 1/6/14, 4/7/14, 7/10/14 and 11/11/14 lacked evidence of quality monitoring of reportable events. In interview on 1/16/15 at 3:10pm, A3 confirmed reportable events were not included in QAPI reports/evaluations. <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and</p>	S000420	The QI Director will be responsible for reporting on reportable events to the PI Committee at its next meeting on 3/10/15 and all future meetings, as well as documenting in the meeting minutes, even when there are none to report.	03/10/2015	

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	<p>visitors.</p> <p>Based on observation, the facility failed to ensure that patient supplies that were past the manufacturer outdate were removed from inventory in 4 of 5 patient care units.</p> <p>Findings:</p> <p>1. During observations beginning at 1400 hours on 01/06/15, the following observations were made in the Emergency Department:</p> <p>(a) In the medication room, a bottle of Betadine prep had an expiration date of 07/14.</p> <p>(b) In the medication room, 2 Chlamydia specimen collection kits had expiration dates of 4/13 and 5/13.</p> <p>2. During observations beginning at 1520 hours on 01/06/15, the following observation was made in the Obstetrics Department:</p> <p>(a) In the nursery, 3 blood collection tubes had expiration dates of 11/14, 11/14 and 9/14.</p> <p>3. During observations beginning at 1545 hours on 01/06/15, the following observations were made in the Surgical Department in Operating Suite #3:</p> <p>(a) In the anesthesia cart, 2 Fiberoptic Bronchoscopy adaptors had expiration</p>	S000554	<p>1. For ER: Outdated supplies were disposed of properly as of 1/6/2015. Effective 3/1/2015, the Emergency Department Manager will be implementing a monthly inspection of the Clean Utility Room for outdated supplies. There will be a log for the Emergency Department Manager to sign once monthly inspection has been completed. The Emergency Department Manager will be responsible for monitoring all future compliance with this regulation in the ER Department.</p> <p>2. For OB: Every month there will be a staff member assigned to complete a thorough inventory/stock check, which will include rotating stock and checking for outdates. There will be a log sheet that the staff will sign and date when this is completed at the end of every month. The Director of ICU/OB will be responsible for monitoring all future compliance with this regulation in the OB Department.</p> <p>3. In OR: The expired items were immediately removed from the cart and replaced with items that were not expired. The cart was then inspected for any additional outdated items. It was then locked and secured. Education of the CRNA's was completed by the Director of Surgery. The responsibility of the anesthesia cart will remain under the care of the CRNA's. They will inspect the cart the first Tuesday</p>	02/20/2015			

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S001118	<p>dates of 6/14 and 3 Pencil Spinal needles had expiration dates of 12/14.</p> <p>4. During observations beginning at 1615 hours on 01/06/15, the following observation was made in the Recovery Room:</p> <p>(a) In the nurse station, the accucheck controls had an expiration date of 12/14.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(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:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the hospital created conditions that may result in a hazard to patients, public, or employees in 2 areas (medical gas storage</p>	S001118	<p>of each month for outdated items. All outdated items will be disposed and replaced with properly dated supplies. A log will be completed by the CRNA's with performance improvement monitored by the Director of Surgery. 4. The accucheck controls were immediately removed and replaced with appropriate controls that were not expired. The Nursing staff of PACU were educated concerning daily checks on accucheck machine for controls and strips for expiration dates. This will be monitored and checked the first Tuesday of each month for expiration dates. Overall compliance will be monitored by the Director of Surgery.</p> <p>The medical gas tanks and the yellow gas storage tanks have been secured. The Director of Physical Plant will be responsible for monitoring future compliance.</p>	01/06/2015	

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S001160	<p>and the boiler room).</p> <p>Findings:</p> <ol style="list-style-type: none"> During tour of the facility on 1/5/15 between 1:30pm and 4:00pm in the presence of P2, physical plant director, in the medical gas storage building, 3 small unsecured medical gas tanks were observed. During tour of the facility on 1/5/15 between 1:30pm and 4:00pm in the presence of P2, in the boiler room, the following was observed: 13 unsecured yellow gas storage tanks indicated to contain R-22 sitting on the concrete floor. On 1/5/15 at 2:30pm, P2 indicated all gas storage tanks should be secured. <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on document review, observation</p>	S001160	1. Hydrocollator water levels are checked daily in process of	01/30/2015

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	<p>and interview, the hospital failed to ensure equipment servicing per manufacturer's recommendations for 2 hydrocollators in the inpatient/outpatient rehabilitation unit.</p> <p>Findings:</p> <p>1. Review of the HYDROCOLLATOR manual indicated in the General Operating Rules #3. CHECK water level daily...#5. CLEAN the tank periodically as described in maintenance portion... and indicated in the MAINTENANCE section #1 Care of Unit, paragraph 2 ... it is necessary to add water daily. The tank should be drained and cleaned periodically (usually every few weeks). Paragraph 2 indicated the interior may be cleaned with detergent or mild disinfectant.</p> <p>2. On 1/5/15 during tour of the facility between 1:30pm and 4:00pm, in the presence of P2, physical plant director, and P7, rehab director, in the inpatient/outpatient rehabilitation (rehab) unit, 2 hydrocollators were observed, temperature/maintenance logs were not noted and were requested.</p> <p>3. At 1:45pm on 1/5/15, P7 indicated maintenance and temperature checks were being completed, but was not</p>		<p>utilization of packs in patient care. Water level was not noted to be low at time of inspection.</p> <p>2. Maintenance of both Hydrocollator units has always been done; new format of cleaning and temperature check logs reflect our long-standing procedure more effectively. See attached.</p> <p>3. In the process of reproducing the cleaning logs, all items (machine cleaning, laundering of covers and temperature checks) were put on one monthly form in error. This led to the discrepancy in daily temp checks per our written procedure. This has been corrected. See attached.</p> <p>4. The Director of Rehab Services will be responsible for monitoring for future compliance.</p>				

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S001164	<p>certain of schedule.</p> <p>4. Review of the document titled Cleaning Chart 2014 indicated once per month "hydroculator", check marks per month for "Hot Pack Covers" and "Hydro. Temps." 1 time per month. The document lacked an identifier for which of the 2 hydrocollators had been recorded on the log sheet, method of cleaning and responsible person; 6 of the 12 recorded temperature checks lacked documentation of who recorded.</p> <p>5. On 1/5/15 at 4:00pm, P7 indicated hydrocollator temperature checks were done once per month, were not needed prior to each patient use due to the temperature was set at and always remained at 160 degrees Fahrenheit and the units were cleaned once per month.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(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:</p> <p>(B) There shall be evidence of preventive maintenance on all</p>				

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	<p>equipment.</p> <p>Based on observation, interview and document review, the hospital maintenance services failed to ensure preventive maintenance documentation for 3 pieces of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During tour of the facility on 1/5/16 between 1:30pm and 4:00pm, in the presence of P2, Physical Plant Director, and P7, Rehabilitation (Rehab) Services Director, in the Rehab, the following was observed: 1 white Health-O-Meter scale with black non-slip mat peeling and curling up and 1 smaller all white scale. Evidence of preventive maintenance (PM) was requested at that time. 2. On 1/5/15 at 1:30pm P2 indicated the above items should have a PM sticker if included in the PM schedule. 3. On 1/5/15 at 1:30pm P7 indicated the above 2 scales were only used if a patient wanted to weigh themselves and agreed maintenance may not have been notified of their use to include in PM. 4. During tour of the facility on 1/5/16 between 1:30pm and 4:00pm, in the presence of P2, in sleep lab #1, a sleep study machine was noted. 	S001164	<ol style="list-style-type: none"> 1. Both bathroom scales were removed from the department since they were for patient convenience only.4. We have a notice from Compumedics that states no PM is needed on the sleep equipment noted in this citation. See attached. 	01/30/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S001172	<p>5. Review of PM documents lacked evidence of the 2 above scales and any sleep study machine.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(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:</p> <p>(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:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, the hospital failed to maintain clean furnishings in 2 instances of 1 area (the rehabilitation unit).</p> <p>Findings:</p> <p>1. On 1/5/15 during tour of the facility between 1:30pm and 4:00pm, in the Rehabilitation unit (Rehab) in the presence of P2, Physical Plant Director,</p>	S001172	The Housekeeping Department will provide cleaning services to all rooms and areas in the Physical Therapy Department. Cleaning will be charted and walk-through inspections will be completed weekly. Equipment used infrequently is now covered to prevent dust collection. Cleaning, including high and low dusting, will be performed routinely in all areas. Shelf tops and cabinets will be cleared of items so they can be	01/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151327	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/06/2015
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	and P7, Rehab Director, the following was observed: Heavy dust on all levels of a 3-tiered cart which held an ultrasound stimulation machine and heavy dust on top of the cabinet in the storage room of the unit.		dusted and cleaned with the appropriate disinfectant cleaner. All Physical Therapy equipment will be terminally cleaned daily with disinfectant to prevent any cross contamination. The Director of Environmental Services will be responsible for monitoring for future compliance.		