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| 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 06/27/2013 |
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| S000000 | <p>This visit was for a State hospital licensure survey.</p> <p>Dates: 6/25/2013 through 6/27/2013</p> <p>Facility Number: 005013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 07/12/13</p> | S000000 | | |

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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| S000312 | <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the contracted Ultrasound Technician (A2) was provided an annual performance evaluation.</p> <p>Findings included:</p> <p>1. Sullivan County Community Hospital Human Resources policy #160.13 (last approved 3/2013) states, "Evaluations are to be completed on all employees except contract employees. It is the responsibility of the contracting</p> | S000312 | We have obtained a copy of the most recent performance evaluation for the identified Ultrasound Technician. DHS (the contracted service) has been notified that we are required to have a copy of the performance evaluation in the HR files of those employees providing services at Sullivan County Community Hospital. The Director of Radiology will be responsible for monitoring and ensuring that we receive a copy of all future performance evaluations. | 07/19/2013 | |

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| | <p>agency to provide evaluations on contract employees. Employees will be evaluated annually from date of current position."</p> <p>2. The Ultrasound Technician (A2) was a contracted staff member Staff member A2 personnel file evidenced performance evaluations. The last evaluation in the file was dated 4/15/05 and was signed by the contracting Supervising Technologist.</p> <p>3. At 2:00 PM on 6/26/2013, staff member #22 indicated the contracted Ultrasound Technician personnel file evidenced the staff member did not have an annual performance evaluation.</p> | | | |

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| 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 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.</p> <p>Based on document review and staff interview, the facility failed to ensure 9 services were part of its comprehensive quality assessment and improvement (QA&I) program:</p> <p>Findings included:</p> <p>1. Sullivan County Community Performance Improvement Plan policy #140.00 (last approved 3/2012) implements all services with direct or indirect impact on patient care quality shall be monitored and evaluated under the quality improvement program.</p> | S000406 | <p>These services have been added to the PI Reporting Schedule to ensure reports are submitted on a quarterly basis per policy. The Department Directors of the respective services have been notified and will begin reporting at the 9/12/13 PI Committee meeting. These QA&I initiatives will be reported to the Medical Staff on 9/16/13 and to the Governing Board on 9/17/13. The QI Director will be responsible for ensuring that QA&I reports are submitted on a quarterly basis.</p> | 07/19/2013 | |

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| | <p>2. The 2012/2013 Quality Improvement data did not evidence 9 services were monitored or evaluated by the facility's quality assessment and improvement (QA&I) program: Audiology, Dental, Infusion Therapy, Mammography, MRI, Pediatrics, PICC Line, Post-Operative Recovery, and Ophthalmic Surgery services</p> <p>3. At 3:15 PM on 6/26/2013, staff member #5 indicated the quality assessment and improvement team do not monitor Audiology, Dental, Infusion Therapy, Mammography, MRI, Pediatrics, PICC Line, Post-Operative Recovery, and Ophthalmic Surgery services.</p> | | | | |

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| S000554 | <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 visitors.</p> <p>Based on observation and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During the tour of the nursery at 2:20 PM on 06/25/13, accompanied by staff members #A3 and A7, two of two Veni-Gard Jr. IV catheter dressings, with an expiration date of 05/2013, were observed on the EKG cart. 2. During the tour of the Med/Surg Unit at 3:30 PM on 06/25/13, accompanied by staff members #A3 and A7, the following lab supplies were observed: <ul style="list-style-type: none"> A. Two of four gold top tubes, one expired 03/2013 and one expired 09/2012. B. Seven of seven small blue top tubes expired 04/2013. 3. During the tour of the Med/Surg Unit at 3:40 PM on 06/25/13, accompanied by staff members #A3 and A7, the Broselow Pediatric Emergency cart was opened and | S000554 | All Code carts, EKG carts, Broselow carts and supply cabinets have been thoroughly inspected for additional outdates/expired items. Each Department Director, as applicable, will be responsible for ensuring that all outdates/expired items are removed as supplies are restocked. | 07/05/2013 | | | |

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| | <p>the following observations made:</p> <p>A. Pink drawer- one of one yellow top lab tube expired 03/2013, one of one blue top lab tube expired 04/2013, and one of one Trocar thoracic catheter expired 02/2013.</p> <p>B. Red drawer- one of one yellow top lab tube expired 03/2013, one of one blue top lab tube expired 04/2013, one of one Trocar thoracic catheter expired 02/2013, and one of two 24 gauge BD Insyte Autoguard catheters expired 10/2012.</p> <p>C. Purple drawer- one of one yellow top lab tube expired 03/2013, one of one blue top lab tube expired 04/2013, and one of one Trocar thoracic catheter expired 02/2013.</p> <p>D. Yellow drawer- one of one yellow top lab tube expired 03/2013, one of one blue top lab tube expired 04/2013, and one of three 18 gauge BD Insyte Autoguard catheters expired 05/2013.</p> <p>E. White drawer- one of one yellow top lab tube expired 03/2013, one of one blue top lab tube expired 04/2013, and one of two 24 gauge BD Insyte Autoguard catheters expired 03/2013.</p> <p>F. Blue drawer- one of one yellow top lab tube expired 03/2013, one of one blue top lab tube expired 04/2013, and one of one Trocar thoracic catheter expired 07/2012.</p> <p>G. Orange drawer- one of one yellow top lab tube expired 03/2013 and one of one blue top lab tube expired 04/2013.</p> | | | | |

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| | <p>H. Green drawer- one of one yellow top lab tube expired 03/2013 and one of one blue top lab tube expired 04/2013.</p> <p>4. At 3:45 PM on 06/25/13, staff member #A7 indicated the supplies and emergency carts were opened and checked monthly by nursing staff and outdates should be removed and replaced.</p> | | | |

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| S000596 | <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(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:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on manufacturer's instructions, observation and staff interview, the facility failed to ensure chemicals were labeled and used correctly to ensure safe and effective cleaning and disinfection in the facility.</p> <p>Findings included:</p> <p>1. OASIS 146 Multi-Quat Sanitizer manufacturer Hospital Disinfection Directions when applied with a spray bottle applicator, the surface must remain wet for 10 minutes.</p> | S000596 | <p>3M HB Quat has been our main disinfectant for the past three years, but is being phased out and being replaced by Diversy Virex 256 and Virex Tb Ready-to-Use Disinfectant Deodorizing Cleaner. This has been a slow transition in order not to waste chemical by throwing out the existing supply. Eventually we will have only the Diversy line of chemicals in use within the hospital and will know the kill times for each. The Bathroom & Shower cleaner is one of the 3M products that is being phased out and will be replaced with the Diversy Crew Tub & Tile Cleaner. During transition until conversion is complete, the dilution, application and kill time of both the old and new solutions will be monitored to ensure</p> | 08/30/2013 |

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| | <p>2. Virex Tb Ready-to-Use Disinfectant Deodorizing Cleaner manufacture's use instructions indicate to allow product to penetrate and remain wet, three minutes for all bacteria, 10-minutes for Tb and 1 minute for HBV and HIV.</p> <p>3. At 11:45 AM on 6/25/2013, the Dietary Department was toured. The Department was observed with 2 spray bottles in the cafeteria and two spray bottles in the kitchen of OASIS 146. A staff member in the kitchen was observed spraying the disinfectant on a prep counter and within 10 seconds the surface was wiped with a dry cloth.</p> <p>4. At 11:50 AM on 6/25/2013, staff member #18 indicated the spray bottles with OASIS 146 are sprayed onto the surface and then wiped off with a dry towel. The staff member indicated he/she did not know the time the surface needs to remain wet before it can be wiped off.</p> | | <p>disinfection is complete. Once conversion is complete, the Director of Environmental Services will be responsible for spot-checking compliance for one month until we are ensured that compliance is effective and complete. After that period, each applicable Department Director will be responsible for monitoring their own staff's cleaning methodology to ensure effective and complete disinfection. See Policy #245.158/530.28. The Director of Environmental Services began two months ago ordering screen printed spray bottles for the Virex 256 for the staff so the labels wouldn't be damaged by moisture or the chemical in the bottles. The Director of Environmental Services will be doing the same for the other chemicals which will be the restroom cleaner and window cleaner. These are the only three chemicals that are mixed through the dispensers. The other two products, Virex TB and the End Bac spray, already come with screen printed labels that have the kill times on them. The Director of Environmental Services will be responsible for purchasing any labeling for mixed gallon bottles and will do a monthly inspection to see what needs replaced. He will also be responsible for educating the Housekeeping staff, as well as departmental staff in the respective departments in which</p> | | |

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| | <p>5. At 11:15 AM on 6/26/2013, three staff members in the Rehabilitation Department (#14, 15, and 16) were asked the procedures on using Virex Tb disinfectant. The three staff members indicated the spray would be sprayed on the surface of the equipment then immediately wiped off with a dry towel. The three staff members indicated they did not know the kill time of the disinfectant they were using.</p> <p>6. During the tour of the obstetrical (OB) unit at 2:30 PM on 06/25/13, accompanied by staff members #A3 and A7, the following chemicals were observed in the housekeeping closet:</p> <p>A. A gallon container of HB Quat disinfectant with a worn and barely legible label.</p> <p>B. A gallon container of Bathroom & Shower Cleaner with a worn and barely legible label and mixing instructions hand-written on the container.</p> <p>C. A clear plastic spray bottle with</p> | | <p>the chemicals are used, on proper use and kill times for the chemicals being used in their department.</p> | |

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| | <p>"Bleach" hand-written on the bottle.</p> <p>7. At 3:00 PM on 06/25/13, the director of environmental services, staff member #A8, was interviewed on the OB unit. He/she indicated the housekeepers used Diversy Virex 256 with a 2-10 minute kill time for disinfection. When staff member #A8 was shown that wasn't the chemical on the OB unit, he/she indicated he/she was not aware that closet had not been changed over yet. He/she also indicated the directions hand-written on the Bathroom & Shower Cleaner were not correct, but the label was.</p> <p>8. During the tour of the surgical department at 11:10 AM on 06/26/13, accompanied by staff member #A24, one spray bottle of solution and one gallon bottle of solution with illegible labels were observed in the decontamination area.</p> <p>9. At 11:10 AM on 06/26/13, staff</p> | | | |

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| | <p>member #A24 indicated the surgical staff knew what the chemicals were and how to use them.</p> <p>10. At 11:20 AM on 06/26/13, HB Quat disinfectant, with a manufacturer labeled kill time of 10 minutes, and Virex TB Spray, with a manufacturer labeled kill time of 3 minutes, were observed in the housekeeping closet in the surgical department.</p> <p>11. At 11:30 AM on 06/26/13, staff member #A24 indicated nursing staff usually used the Dispatch spray for cleaning the operating rooms between patients and just sprayed it on and wiped it off with a dry rag, only leaving the chemical on for a few seconds. Manufacturer labeled kill time was to remain wet for at least one minute.</p> <p>12. At 11:45 AM on 06/26/13, housekeeping staff member #A28 indicated he/she used both the</p> | | | |

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| | <p>Dispatch spray and the HB Quat for disinfection and sometimes allowed the chemicals to dry for a few minutes, but not always if the rooms were very busy.</p> <p>13. At 2:00 PM on 06/2713, staff member #3 confirmed the discrepancies with the use of various chemicals and following manufacturer's directions for effectiveness and that the labeling of the chemicals was a problem.</p> | | | | |

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| S000598 | <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</p> <p>(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:</p> <p>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on documentation review, observation and staff interview, the facility failed to ensure the Ultrasound Gel containers were properly disinfected before they were refilled with Liquid Sonic Ultrasound Gel located in the Radiology Ultrasound room.</p> <p>Findings included:</p> <p>1. FDA indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. However, past studies have demonstrated that</p> | S000598 | All departments using the ultrasound gel will begin using only the 16 oz bottles and will stop using the bulk manufacturer containers for refills. The Directors of those areas in which ultrasounds are performed (Radiology, ER and OB) will be responsible for monitoring compliance. | 08/01/2013 |

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| | <p>ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA recommends that Ultrasound Gel containers not to be refilled.</p> <p>2. At 10:30 AM on 6/26/2013, the Radiology Department Ultrasound room was inspected. Located in the room was a table with eleven 16-ounce ultrasound gel containers adjacent to a thermal sonic warming unit. The room did not have any sterile processing for the gel containers before they were refilled. The containers are refilled with the Gel from a bulk manufacturer container.</p> <p>3. At 10:40 AM on 6/26/2013, staff member #12 indicated he/she refills the ultrasound gel plastic bottles without sterilizing and/or disinfecting the containers before they are refilled. However,</p> | | | |

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| | sometimes the containers might be rinsed out first. The staff member indicated he/she understands the critical necessity of proper disinfecting of the containers or not to refill the containers at all. | | | |

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| S000606 | <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</p> <p>(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:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on document review and staff interview, the hospital failed to monitor information about health and activities as they relate to diseases that are transmissible through food for 2 of 5 kitchen staff workers. (A9 and A15)</p> <p>Findings:</p> <p>1. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment shall require food employee applicants to whom a</p> | S000606 | All current staff have reviewed and signed the Infection Control document. All new hires will review and sign during General Orientation. Each staff member will be asked to review and re-sign the document during their annual performance evaluation. The Nutritional Services Director will be responsible for ensuring the Infection Control document is signed and in each employee's HR file. | 07/23/2013 | | | |

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| | <p>conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food."</p> <p>2. Sullivan County Community Hospital Infection Control procedure (last approved 5/2013) requires every food service worker to sign a document indicating they were notified to report any food related illness or food related diseases to the person-in-charge.</p> <p>3. On 6/22/2010 and 6/23/2010, two staff members (A9, A15) personnel records provided did not identify that the food service staff signed the food service worker delineation form about their health and activities as they relate to diseases that are transmissible through food.</p> <p>4. At 2:30 PM on 6/26/2013, staff member #22 indicated food service staff member's A9 and A15 did not</p> | | | |

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| | have the signed Infection Control document which all food service workers are required to sign. | | | |

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| S000612 | <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(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:</p> <p>(xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on document review, observation and staff interview, the facility failed to ensure the Laundry Department had a written procedure on proper washing and handling of soiled/clean linen through the washing cycles.</p> <p>Findings included:</p> <p>1. Sullivan County Community Environmental Services/Housekeeping/Laundry policy #245.63/530.09 (Last approved 3/2012) described how to handle clean and soiled linen</p> | S000612 | Policy #245.63/530.09, Clean Linen Carts/Clean Linen Distribution/Soiled Linen Collection/Safety Procedures, was revised as follows:1. The cycles in which bleach is added (Cycle 4 for Medium Soil Cotton & Terry Cloth and Cycle 6 for Heavy Soil) will have hot water for the wash cycle and for the bleach cycle, then go to a gradual cool down for each step to the final rinse.2. The cycles in which bleach is not added (Cycle 1 for OB Bedspreads, Sleep Lab linens, and table linens; Cycle 2 for Housekeeping mops and cleaning rags; and Cycle 3 for hospital scrubs) will have a 25 minute wash cycle for CDC requirements.We will be switching to an oxygen bleach as suggested by the surveryor once | 10/01/2013 | |

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| | <p>through storage of linen; distribution of linen; collection of soiled linen; and safety procedures on handling of linen. However, section #13 describes on how to maintain the washers and dryers in a sanitary manner. The section does state, "Only approved laundry chemicals and compounds are to be used in the washers. Laundry chemicals are automatically metered for each predetermined wash cycle." The policy does not specify how to operate the washers; what each cycle was for; and guidelines on the operation of the washers and dryers.</p> <p>2. Sullivan County Community Hospital Infection Control policy #245.59/530.08 (Last approved 2/2012) indicates the Laundry Department shall comply with CDC Guidelines for Environmental Infection Control in Healthcare Facilities, 2003.</p> <p>3. CDC guidelines for laundry services in health care facilities</p> | | <p>our Laundry renovation project is complete. It is our understanding that this will eliminate the need for the 25 minute wash cycle. In response to the issue regarding the washers' weight capacity, the load capacity has been added to the policy. The Director of Environmental Services will spot-check the weight of wash loads biannually by selecting 5 random loads to weight, according to washer size, for proper washer performance and linen processing. The Director of Environmental Services will be responsible for monitoring and ensuring future compliance with this regulation.</p> | | | | |

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| | <p>states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled at a residual of 50-150 ppm during the chlorine bleach cycle."</p> <p>4. The Laundry Department was toured at 12:15 PM on 6/26/2013. The Department was a one room Department with two industrial washers and dryers. The room was observed with industrial chemicals feeding into the two industrial washers. The room did not have a scale for weighing the laundry for</p> | | | |

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| | <p>washers. One of the two washers was observed filled with fiber mop heads.</p> <p>5. At 12:20 PM on 6/26/2013, staff member #8 indicated the Laundry Department does not have any written procedures on each cycle the washers are calibrated for. The staff member indicated the washers are calibrated for five different cycles. None of the five cycles operate on hot water longer than 23 minutes. Cycle 1, 2, and 3 only operates with 160 F hot water for 7 or 8 minutes each. None of the cycles utilizes bleach during the operation of each cycle. The laundry and linen that are washed through the cycles are: OB Bed spreads, sleep lab linen, table linens, HSKP fiber mops and cleaning rags, and hospital scrubs. The staff member indicated the reason bleach was not used was due to preserving the color or destroying the properties of the rags or fiber mops. The staff member indicated he/she did not know the</p> | | | |

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| | CDC guidelines for washing health care laundry in a hospital. The staff member indicated the washing loads for each washer was 40 pounds; however, the staff did not use scales to make sure the loads do not exceed the washing capacity for the washers. | | | |

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| S000868 | <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed: (i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff; (ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or (iii) within forty-eight (48) hours after an admission.</p> <p>Based on policy and procedure review, medical record review, and interview, the facility failed to ensure all patients had History and Physicals or updates within 24 hours of admission for 2 of 2 obstetrical medical records reviewed (#N3 and N5).</p> <p>Findings included:</p> <p>1. The facility policy "History and Physical", last reviewed April 2013, indicated, "Each inpatient medical record shall contain a history and physical examination completed within 24 hours</p> | S000868 | The OB H&P Update form is a part of the new patient admission packet and is, therefore, a part of each medical record. The OB Nursing staff will begin flagging this form for physician signature as a reminder for the physicians to update the H&P and sign/date the form. All OB Staff have been re-educated on this topic. The Director of ICU/OB and the Director of Medical Records will be responsible for implementing a 3-6 month QA&I project for the deficiency and for ensuring ongoing compliance. | 11/01/2013 |

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| | <p>of admission."</p> <p>2. The medical record for patient #N3, who was admitted in labor on 03/09/13, indicated the form "OB H&P Update: 1. Prenatal H&P in medical record and a..H&P valid with no changes" signed by the physician and dated 4/28/13.</p> <p>3. The medical record for patient #N5, who was admitted in labor on 11/29/12, indicated the form "OB H&P Update: 1. Prenatal H&P in medical record and a..H&P valid with no changes" signed by the physician and dated 12/10/12.</p> <p>4. At 1:30 PM on 06/26/13, staff member #A23, who navigated the EMR (Electronic Medical Records), confirmed the physician H&P updates were not completed timely and according to policy.</p> <p>4. At 12:30 PM on 06/27/13, staff member #A3 also confirmed the findings and indicated the updates should be completed within 24 hours of admission.</p> | | | | |

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| S000870 | <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.</p> <p>Based on medical record review and interview, the facility failed to ensure all procedures performed had a physician's written or verbal order for 2 of 2 newborn infant males (#N6 and N8).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the medical record for patient #N6, a male infant born 11/29/12, indicated physician documentation of a circumcision performed 11/30/12, but lacked documentation of a written or verbal order for the procedure. Review of the medical record for patient #N8, a male infant born 12/15/12, indicated physician documentation of a circumcision performed 12/16/12, but | S000870 | <p>This specific citation was reviewed and discussed during the Nursing Administration meeting on 7/17/13. The Director of ICU/OB will be responsible for ensuring that OB staff receive re-education on the necessity of an order and a signed informed consent for circumcisions. The Medical Staff will be informed of this citation at the next OB Committee meeting on 8/29/13 and reminded of the necessity of an order and signed informed consent prior to any procedure. The Director of ICU/OB will be responsible for ensuring ongoing compliance and auditing charts to ensure that compliance is achieved.</p> | 10/01/2013 | |

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| | <p>lacked documentation of a written or verbal order for the procedure.</p> <p>3. At 1:30 PM on 06/26/13, staff member #A23, who navigated the EMR (Electronic Medical Records), confirmed the lack of physician orders for records #N6 and N8.</p> <p>4. At 12:30 PM on 06/27/13, staff member #A3 also confirmed the findings and indicated all procedures should have a physician's order.</p> | | | |

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| S000930 | <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on medical record review, policy and procedure review, and interview, the nurse executive failed to ensure assessments were done according to policy for 2 of 2 pediatric patients admitted to the facility (#N13 and N14).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The medical record for patient #N13, a 15 month old admitted for convulsions on 02/12/13, lacked documentation of a head circumference measurement in the nursing admission assessment. 2. The medical record for patient #N14, an 11 month old admitted for fever on 12/10/12, lacked documentation of a head circumference measurement in the nursing admission assessment. 3. The facility policy "Pediatric Admission Assessment Form", last revised 04/13, indicated, "1.11 Measure and document head circumference in the | S000930 | <p>A Head Circumference intervention was activated in the EMR and made a required assessment for the pediatric assessment for patients 1-3 years of age. The EMR will not allow the nurse to exit the assessment without completing all required fields. The Pediatric Assessment policy was revised to include head circumference for all pediatric patients up to 3 years of age. The Director of Med/Surg will be responsible for monitoring and ensuring ongoing compliance.</p> | 07/12/2013 | |

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| | <p>0-2 year old."</p> <p>4. At 1:30 PM on 06/26/13, staff member #A23, who navigated the EMR (Electronic Medical Records), confirmed the lack of the head circumference measurement for pediatric records #N13 and N14.</p> <p>5. At 12:30 PM on 06/27/13, staff member #A3 also confirmed the findings and indicated the EMR would automatically prompt the nurse if the assessment for an infant under 12 months was selected, but not for a toddler of 1-3 years.</p> | | | |

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| S001118 | <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 documentation review and observation, the facility failed to provide an eye wash station in the Main Housekeeping Storage Area when required.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Sullivan County Community Hospital Safety policy #520.41 (Last approved 1/2013) indicates the facility shall comply with OSHA standards for safety of the employee in the workplace. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, | S001118 | <p>There is currently an eye wash station in the Laundry area, but not in the specific Housekeeping Storage closet cited. The Laundry area is currently under complete renovation. An eye wash station will be added to the remodel plans for the future Housekeeping Storage closet. The Director of Physical Plant and the Director of Environmental Services will be responsible for ensuring the eye wash station is added to the remodel plans. The Director of Environmental Services will be responsible for conducting future tests of the eye wash station per requirements.</p> | 09/30/2013 | |

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| | <p>facilities for drenching or flushing the eyes shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>3. At 12:05 PM on 6/26/2013, the Main Housekeeping Storage Area was toured. The room was observed charging the batteries to an industrial floor scrubber. The batteries are also checked routinely for proper water levels within the batteries. The room also contained a shelf with a 5-gallon container of floor stripper that is diluted in the room. The container indicates there</p> | | | | |

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| | needs to be 15-minute of continuous eye flushing with water if the chemical comes in contact with a person's eyes. The room did not have an eye-wash station. | | | |