

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2012
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NAME OF PROVIDER OR SUPPLIER DAVIESS COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 E WALNUT ST WASHINGTON, IN 47501
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 005056</p> <p>Survey Dates: 10-1/2-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratorian</p> <p>QA: cloughlin 11/02/12</p>	S0000	No response required.	

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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S0102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on document review, the facility failed to comply with all applicable state laws for 2 of 2 noncertified nursing assistant employee files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. 2. Review of employee #N4's employee file indicated that he/she was hired on 1/16/12 as a Nursing Assistant. The file lacked documentation of a nurse aide registry report. 3. Review of employee #N5's employee file indicated that he/she was hired on 	S0102	<p>#1 #2 #3 #4 WHO: Director of Human Resources is responsible for the implemenatation and monitoring of the improved process that is to be monitored initially on a monthly basis for the first 3 months (Nov, Dec, Jan.) and then quarterly. WHAT: lack of documentation of nurse registry report WHEN: 11/19/2012 HOW: nurse aide files were audited and when lacking the online state website was queired and the report posted to their employee file. This process was completed on 11/19/2012. The HR checklist was updated to reflect queiries for non licensed personnel.</p>	11/19/2012	

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	<p>6/4/12 as a Nursing Assistant. The file lacked documentation of a nurse aide registry report.</p> <p>4. Staff member #9 verified the above in interview at 3:25 p.m. on 10/2/12.</p>				

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S0266	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(4)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(4) Review the bylaws at least triennially.</p> <p>Based on document review and interview, the Governing Board failed to follow the hospital's approved Bylaws.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the Governing Board Bylaws on 10-1-12 and 10-2-12 lacked documentation that the bylaws were last reviewed/revised 9-27-07; review of the Governing Board Bylaws lacked signatures of the Board of Governors President and Secretary and a date on the signature page. 2. Review of the Governing Board Bylaws on 10-2-12 indicated the following: The Board of Governors must review its Bylaws every two (2) years and date the Bylaws to indicate the time of the last review. 3. Interview with B#9 on 10-2-12 at 1445 hours confirmed documentation indicated the most recent approval of the Governing Board Bylaws is 9-27-07 and the 	S0266	<p>1,2,3 WHO: CEO WHAT: Board accepted current bylaws as they are written. WHEN: 11/19/12 QHR acknowledged receipt of Bylaws. 11/20/12 Board President Signed off on current bylaws HOW: The Quality Director will be responsible for brings forth bylaws for review and approval to the Governing Board (at least) on a biennial basis. Our CEO and Board have requested that (QHR our managing company) also review and make recommendations on our bylaw by 4/30/13.</p>	11/20/2012

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	signature page lacked a date and signatures of the Board of Governors President and Secretary.			

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S0556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on observation, document review, and interview, the facility failed to have an effective infection control program to reduce the risk of spreading disease and infection to patients, staff, and visitors.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During the tour of the laboratory on 10/2/12 at 12:15 p.m., it was observed that a large yellow stuffed toy animal was sitting on the phlebotomy draw table in the laboratory's phlebotomy drawing room. 2. In interview on 10/2/12 at 12:15 p.m., staff member #9 acknowledged this toy had not been disinfected or cleaned between possible interactions with children who had blood draws in this phlebotomy room. 	S0556	<p>The Infection Control Officer will be responsible for monitoring all plans of corrections and the individual department managers are responsible for implementing each of their plans as stated below.#1 & #2. WHO: Laboratory Director WHAT: threw away the stuffed yellow duck WHEN: 10/2/12 HOW: Staff were re-educated regarding infection control and not to bring items into phlebotomy room that don't have surfices that can be sanitized. #3 & #4 WHO: Environmental Services Manager WHAT: Paper towels, boxes of gloves, velco strips, 2 blow dryers, and saran wrap WHEN: 10/5/12 HOW: Paper towels and gloves were removed and now stored in warehouse and clean utility room. the dryers were sanitized, bagged and labeled "clean" and placed in the clean utility room. The saran wrap was thrown away. Staff were re-educated to not store any type of supplies that would be used by patients or staff</p>	11/29/2012			

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			<p>in the dirty utility for any reason. #5 #6 #7 WHO: Emergency Department Director WHAT: out dates on crash carts of needles, IV catheters, pre-filled syringes of sodium chloride, a multi-lumen CVC kit, CO2 indicator, nasogastric tube, and a supraglottic airway were all removed and discarded. WHEN: 10/2/2012 supplies replaced. How: each unit manager checked and replaced supplies on crash carts same day as survey. Improvement Plan: as stated in policy in #6 the ED Director has assigned responsibility of checking crash carts content to her department on a monthly bases schuled starting date is Thursday November 29, 2012. This process was in effect previously and was changed at some point and is now reverting back to its original process which worked well. #8 #9 WHO: Emergency Department Director WHAT: Infection Control breach, RN wearing soilded gloves contaminated medication which were then discarded. WHEN: 10/2/2012 HOW: the RN was counseled by his/her supervisor regarding the observed breach in infection control. All nursing staff receive infection control education upon hire duing orientation and at a minimum on an annual basis. The nurse manager and the infection control nurse monitor infection control practices of staff as part of their</p>		

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	3. During facility tour beginning at 10:30 a.m. on 10/2/12 and accompanied by staff member #1, the following items were observed in the soiled utility rooms: (A) A large box of saran wrap and two (2) hairdryers were observed stored in the soiled utility room on the medical/surgical		responsibilities. Infractions are dealt with on an individual basis by the responsible manager. #10 through #14 WHO: Director of Radiology WHAT: Review of Ultrasound Department Cidex Strip Test Log showed lag in changing solution every 14 days as directed by manufacturer. WHEN: 10/02/2012 corrected documentation process HOW: what the log did not reflect was when solution was discontinued (thrown away) and no new solution mixed because there were no studies scheduled. A new batch is mixed dated with start and end date the next time the probes are to be used. It can sometimes be days before the next time the probe would be in use. It is the responsibility of each ultrasound technologist that may be using any of the probes to complete and mange this task. Staff have been instructed to record on the log the date that the solution has been discarded if they are not replacing it that same day. Staff received verbal education followed with a written memo and a copy of the probe disinfection policy.		

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	<p>unit.</p> <p>(B) Paper toweling and toilet paper were observed stored in the soiled utility room on the rehab unit.</p> <p>(C) Paper toweling and boxes of gloves were observed stored in the soiled utility room on the intensive care unit.</p> <p>(D) Paper toweling, toilet tissue, and Velcro strips were observed stored in the soiled utility room in the emergency department.</p> <p>4. Staff member #1 verified the above storage of supplies during the tour.</p> <p>5. During facility tour beginning at 10:30 a.m. on 10/2/12 and accompanied by staff member #1, the following expired patient care items were observed:</p> <p>(A) Five (5) 18 1/2 " needles with an expiration date of 3/12 and one (1) IV catheter with an expiration date of 2/12 were observed in the crash cart on the medical/surgical unit.</p> <p>(B) Three (3) 18 G 1 1/2" needles with an expiration date of 3/12, five (5) 23 G 1" needles with an expiration date of 5/12, two (2) 10 ml pre-filled syringes of Sodium Chloride with an expiration date of 7/12, one (1) 10 ml pre-filled syringes of Sodium Chloride with an expiration date of 5/1/12, and one (1) 10 ml pre-filled syringe of Sodium Chloride with an expiration date of 3/1/12, and one (1) multi-lumen CVC kit with an expiration date of 7/11 were observed in</p>						

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	<p>the crash cart on the rehab unit.</p> <p>(C) One (1) C02 indicator with an expiration date of 1/12, one (1) 22 G 1 1/2 " needle with an expiration date of 7/11 and three (3) 22 G 1 1/2 " needles with an expiration date of 8/12, one (1) I.V. catheter kit with an expiration date of 9/12, one (1) nasogastric tube with an expiration date of 9/11, and one (1) nasogastric tube with an expiration date of 8/12 were observed in the crash cart on the intensive care unit.</p> <p>(D) One (1) Supraglottic airway with an expiration date of 6/12 was observed in the anesthesia cart in the surgery department.</p> <p>6. Facility policy titled "Daily Defibrillator and Crash Cart Checks" last reviewed/revised 8/12 states on page 1, under policy: "All other contents of the crash carts kept on patient care units will be checked for completion and for outdated supplies by the EMS Director every month."</p> <p>7. Staff member #9 verified the above expired items during the tour and verified there was no documentation that the monthly check of outdated supplies by EMS takes place.</p> <p>8. The following breach in infection control technique was observed during tour of the emergency department beginning at 12:20 p.m. on 10/2/12 and accompanied by staff member #1:</p>			

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	<p>(A) RN #1 was called away from medication preparation for a patient brought in and additional staff were required. He/she came out of the patients room wearing gloves where a second staff member indicated there was emesis and blood involved. RN #1 proceeded to pick up the medication vials and syringe he/she had been working with prior to being called to the room with the soiled gloves on.</p> <p>9. Staff member #10 verified the above and requested RN #1 to remove the gloves and to destroy the medication due to contamination.</p> <p>10. While touring the radiology department with B#6 and B#7 on 10-2-12 at 1030 hours, it was observed that intra-cavity ultrasounds are being performed.</p> <p>11. Review of the Ultrasound Department Cidex Strip Test Log documentation on 10-2-12 at 1045 hours indicated the Cidex OPA 14 day solution was documented as changed on the following dates:</p> <p>a.) 9-15-11 and changed on 9-30-11; 15 days</p> <p>b.) 9-30-11 and changed on 10-19-11; 19 days</p> <p>c.) 10-19-11 and changed on 11-16-11; 28 days</p> <p>d.) 11-16-11 and changed on 12-1-11; 15 days</p>				

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	<p>e.) 12-15-11 and changed on 2-7-12; 54 days</p> <p>f.) 2-21-12 and changed on 3-12-12; 20 days</p> <p>g.) 3-26-12 and changed on 4-13-12; 18 days</p> <p>h.) 5-28-12 and changed on 6-29-12; 32 days</p> <p>i.) 6-29-12 and changed on 7-15-12; 16 days</p> <p>j.) 7-15-12 and changed on 8-17-12; 33 days</p> <p>k.) 8-17-12 and changed on 9-17-12; 31 days</p> <p>12. Review of the manufacturer's instructions on the Cidex OPA container on 10-2-12 indicated the following: Do not reuse beyond 14 days or sooner as indicated by Cidex OPA Solution Test Strips.</p> <p>13. Review of facility policy titled INTRA-CAVITY PROBE DISINFECTION, reviewed/revised 8/11 indicated the following: The Cidex OPA in the disinfection canister will be discarded after 14 days of use.</p> <p>14. Interview with B#7 on 10-2-12 at 1100 hours confirmed the facility policy indicated to discard the Cidex OPA solution after 14 days; B#7 confirmed the manufacturer's instructions indicated not to reuse beyond 14 days or sooner as indicated by the Cidex OPA Solution Test Strips; B#7 confirmed the documentation</p>				

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	<p>on the Ultrasound Department Cidex Strip Test Log indicated the solution was changed on the following dates:</p> <p>a.) 9-15-11 and changed on 9-30-11; 15 days</p> <p>b.) 9-30-11 and changed on 10-19-11; 19 days</p> <p>c.) 10-19-11 and changed on 11-16-11; 28 days</p> <p>d.) 11-16-11 and changed on 12-1-11; 15 days</p> <p>e.) 12-15-11 and changed on 2-7-12; 54 days</p> <p>f.) 2-21-12 and changed on 3-12-12; 20 days</p> <p>g.) 3-26-12 and changed on 4-13-12; 18 days</p> <p>h.) 5-28-12 and changed on 6-29-12; 32 days</p> <p>i.) 6-29-12 and changed on 7-15-12; 16 days</p> <p>j.) 7-15-12 and changed on 8-17-12; 33 days</p> <p>k.) 8-17-12 and changed on 9-17-12; 31 days</p>				