

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 005038</p> <p>Survey Dates: 04-16/18-11</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: claughlin 05/03/12</p>	S0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591		
(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	
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 3 of 3 unlicensed 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 staff member #N2 employee file indicated that he/she was hired in 7/11 as a tech/nursing assistant. The file lacked documentation of a nurse aide registry report. 3. Review of staff member #N7 employee file indicated that he/she was hired in 	S0102	<p>Beginning 5/1/12, the Human Resources Department will begin to check certification and/or licensure status on all currently employed nursing support staff such as nurse assistants, multi-skilled workers and psychiatric nurse assistants with hire dates of 1/1/2010 to 5/1/12. All new hires in these categories effective 5/1/12 will have this verification of certification/licensure applied for within three days of hire. HR staff will verify the presence or lack of certification/licensure and any pending litigation through the appropriate state agencies. Human Resources Policy 439 was revised on 5/23/12 to reflect this process.</p>	05/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591		
(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	
	<p>5/11 as a tech/nursing assistant. The file lacked documentation of a nurse aide registry report.</p> <p>4. Review of staff member #N14 employee file indicated that he/she was hired in 5/11 as a tech/nursing assistant. The file lacked documentation of a nurse aide registry report.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591		
(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	
S0178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and interview, the facility failed to post a copy of their license at the 1st Street Surgery Center.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. While touring the surgery center on 1st Street on 4-18-12, it was observed that a copy of the hospital license was not posted in this building. 2. Interview with B#13 on 4-18-12 at 0935 hours confirmed the hospital license is not posted at the 1st Street surgery center and the surgery center is included under the hospital's license. 	S0178	<p>On 4/18/12 a copy of the current hospital State license was posted in the lobby of the First Street Surgery Center by the Director of Ambulatory Surgery. Posting of all licensures will be added to the annual EOC tours check list for all facilities to verify all current licenses are displaced as required.</p>	04/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591		
(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	
S0554	<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, the facility failed to ensure it provided an environment that minimized exposure risk to patients for 1 emergency department (ED) toured.</p> <p>Findings include:</p> <p>1. During tour of the ED beginning at 12:10 p.m. on 4/17/12, the following was observed:</p> <p>(A) A bedside commode was observed in the soiled utility room. The commode was identified by staff as clean. Tech #1 came to the room and removed the commode for patient use. The commode could have been contaminated with biohazardous material due to storage within a soiled utility room.</p>	S0554	<p>On 4/17/12 the commode noted in the citation was removed from the soiled holding area, re-cleaned and placed in a clean area of the department at the direction of the Emergency Department Director. During May department meetings all staff were educated on not placing this commode or any clean items in the soiled holding. Random spot checks will be done to verify compliance.</p>	04/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591			
(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			
S0930	<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 document review and staff interview, the facility failed to ensure a registered nurse evaluated the care provided and followed physician orders for 1 of 2 open critical care (CCU) records, 1 of 2 closed CCU records, and 1 of 1 open surgical unit records reviewed (patients #N15, #N21 and N23).</p> <p>Findings include:</p> <p>1. Review of patient #N15 CCU closed medical record indicated the following: (A) An order was written on 2/24/12 for neuro checks every 2 hours. (B) The medical record lacked documentation that neuro checks were performed per order > 10 times, including but not limited to, no neuro check at 5:00 a.m., 9:30 a.m., 1:30 p.m. and 5:30 p.m. on 2/25/12.</p> <p>2. Review of patient #N21 surgical unit open medical record on 4/17/12 indicated the following: (A) He/she had an order written on</p>	S0930	<p>During May staff meetings the inpatient nursing Managers will discuss with the staff the criticality of following all orders for patients. Bulletin boards and unit web pages will also be utilized to convey the importance of completion of all orders. This communication will be completed by May 31, 2012. Nurse managers or their designee will audit 5 randomly selected charts per week, for a hospital total of 30 per week, for compliance of daily weights, glucose meter checks and/or neurochecks as per physician order. All audit reports will be sent to the respective director each Monday until further notice. This data collection will be done for a duration of 6 months with a goal of 100% compliance. Monitoring will be reported monthly at the Hospital Wide Performance Improvement Meeting. Any inpatient unit with less than 100% during the initial 6 month monitoring will continue to monthly monitoring until there is 6 months of satisfactory compliance. Individual staff responsible for noncompliance will be placed on an individual</p>	05/31/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591		
(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	
	<p>4/12/12 for daily weights. (B) The medical record lacked documentation of a daily weight on 4/13/12.</p> <p>3. Review of patient #N23 CCU open medical record indicated the following: (A) He/she had an order written on 4/9/12 for neuro checks every 2 hours x 24 hours and daily weights. (B) The medical record lacked documentation that neuro checks were performed per order. The neuro checks were not documented at 9:00 a.m. and 1:00 p.m. on 4/10/12. (C) The medical record lacked documentation of a daily weight on 4/14/12.</p> <p>4. Staff member #3 verified the medical record information at 11:15 a.m. on 4/18/12.</p>		performance improvement plan.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591			
(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			
S1020	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on observation, document review, and interview, the pharmacy failed to provide monthly inspections at the surgery center on 1st Street as required by facility policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the 1st Street Surgery Center on 4-18-12 at 0920 hours, a bag of expired medications, labeled expired, were bagged and on a shelf in the locked medication cabinet. 2. Review of facility policy titled MEDICATION STORAGE AND LABELING on 4-18-12 indicated the following under evaluation #5. During monthly unit inspections, Pharmacy staff will verify compliance with all aspects of the medication storage policy and document any deviations from policy on 	S1020	<p>On 4/18/12 the Director of Ambulatory Surgery discussed monthly medication inventory checks for expired medications with the Director of Pharmacy. It was decided as per other hospital locations, the First Street Surgery Center will have monthly checks for expired medication and a key will be provided to the Pharmacy employee to pick up expired medications which have already been removed by the nursing staff and locked in a specific cabinet to be returned to Pharmacy also. Monthly monitoring will be done by the Director of Ambulatory Surgery or her designee on an on-going basis randomly each month to verify all expired medications have been picked up by Pharmacy staff with a goal of 100%. This data will be reported at Hospital Wide PI quarterly for one year.</p>	04/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591
---	--

(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
	<p>the "Pharmaceuticals Inspection Review" form.</p> <p>3. Interview with B#13 on 4-18-12 at 0955 hours indicated pharmacy inspects the medication storage areas at the surgery center quarterly.</p> <p>4. Interview with B#12 on 4-18-12 at 0955 hours indicated pharmacy has the code to open the door to the medication storage room to deliver medications to the surgery center, but does not have keys to the medication cabinets; the bag of expired medications is in the locked cabinet and has not been picked up by pharmacy because the nurse has been busy when pharmacy delivered medications and could not stop to unlock the cabinet in the medication room.</p> <p>5. Interview with B#21 on 4-18-12 at 1115 hours indicated pharmacy delivers medications to the 1st Street Surgery Center but does not conduct monthly unit inspections as required by facility policy.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591		
(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	
S1024	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on observation, interview, and document review, the facility failed to ensure outdated or unusable drugs were removed from stock for 1 anesthesia cart.</p> <p>Findings include:</p> <p>1. During tour of the surgery department beginning at 11:00 a.m. on 4/17/12, the following were observed in an anesthesia cart:</p> <p>(A) One (1) open 20 ml. vial of .9% Sodium Chloride. The vial was marked single dose only and had not been discarded after use. The vial had no date or initials and it could not be determined how long it had been in use.</p> <p>(B) One (1) open 10 ml. vial of</p>	S1024	<p>During April staff meeting the Director of Ambulatory Surgery discussed the hospital policy "Medication Storage and Labeling" with all staff emphasizing the dating of multiple use vials to be discarded 28 days after opening by the person opening the vial as per policy. Staff was also instructed to make sure all single use vials were discarded immediately after use. Random monitoring will be done monthly on an on-going basis by the Director of Ambulatory Surgery or her designee with a goal of 90%. This data will be reported quarterly at Hospital Wide PI for one year.</p>	04/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591		
(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	
	<p>Neostigmin. The vial was marked multi-dose, however had no initials or date as to when it was opened per facility policy. It could not be determined how long the vial had been in use.</p> <p>2. RN #1 indicated at the time of the observation that nursing marks vials and discards vials as needed for the anesthesia provider.</p> <p>3. Facility policy titled "MEDICATION STORAGE AND LABELING" last revised 12/11 states on page 2: "7. Manufacturer's multiple dose vials (MDV) will be used for not more than 28 days from the date of first use or the manufacturer-assigned expiration date, whichever is shorter.....At the time the vial is first used, the person opening the vial will write a date which is 28 days from he current date."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591			
(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			
S1118	<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 facility created a condition which may result in a hazard/harm to facility employees and vendors.</p> <p>Findings include:</p> <p>1. While touring the facility on 4-17-12 at 1130 hours, in the presence of #S4, #S6, and #S7, three (3) fire extinguishers were observed unsecured in the maintenance shop; one fire extinguisher was unsecured on the floor next to a box of 9 secured fire extinguishers and 2 fire extinguishers were laying on their sides unsecured on top of the cardboard box of secured fire extinguishers.</p> <p>2. Interviews with #S4, #S6, and #S7 on 4-17-12 at 1130 hours respectively confirmed the observation of three (3) unsecured fire extinguishers in the maintenance shop.</p>	S1118	<p>On 4/17/12 at 12 noon the three fire extinguishers observed to be unsecured (1 on the floor and 2 on top of the box) as well as those in the box were removed and deployed to the proper location by the Facility Plant Supervisor as directed by the Director of Engineering. Random spot checked will be conducted on an on-going basis by the Engineering Department Director or his designee to verify continued compliance.</p>	04/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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