STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHNECK MEDICAL CENTER	411 W TIPTON ST SEYMOUR, IN 47274

(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
S000000	This visit was for a State hospital licensure survey. Dates: 7/8/2013 through 7/10/2013 Facility Number: 005060 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 07/29/13 9/26/13 Revised due to IDR	S000000	Preparation and execution of this Plan of Correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S000308	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (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: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on review of personnel files and interview, the governing board failed to ensure all employees received departmental orientation in 3 of 3 EVS (environmental services staff) files reviewed (#P7, P8, and P9) and failed to ensure the orientation was complete for 1 of 8 RNs (registered nurses) (#P11) and for 1 of 2 LPNs (licensed practical nurses) (#P18) files reviewed. Findings included: 1. The personnel file for EVS staff member #P7, hired 03/22/10, lacked documentation of orientation to the specific jobs, procedures, and tasks that he/she was expected to perform. 2. The personnel file for EVS staff	S000308	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A job specific orientation checklist template, to compliment our existing department orientation process, will be developed by 8/28/2013 to be used org wide. (Attachment 1) 2. How are you going to prevent the deficiency from recurring in the future? a) The job specific orientation checklist will be required documentation and upon orientation completion the document will be turned into HR to ensure compliance. b) The org-wide Orientation for Excellence policy will be updated. 3. Who is going to be responsible for numbers 1 and 2 above? #1 - responsible person -- Director Staff Development #2 - responsible persons for	10/27/2013

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	member #P8, hired 01/11/10, lacked documentation of orientation to the specific jobs, procedures, and tasks that he/she was expected to perform. 3. The personnel file for EVS staff member #P9, hired 08/22/11, lacked documentation of orientation to the specific jobs, procedures, and tasks that he/she was expected to perform. 4. At 1:25 PM on 07/10/13, staff members #A35 and A35, EVS managers, provided a one page orientation sheet for each employee that covered generic information such as a tour of the hospital and department, reporting structure, and paperwork. Both staff members confirmed there was no documentation of specific orientation to cleaning procedures, chemicals, isolation precautions, etc. 5. Review of the "Unit Specific Department Orientation Checklist" for staff member #P11, an RN hired 05/14/12, had 70 line items/tasks left blank with no explanation as to why he/she was not oriented or signed off in those areas. The form was signed by a preceptor on 06/12/12. 6. Review of the "Unit Specific Department Orientation Checklist" for		the completing the checklist and turning in to HR -- Department Directors or designee. #2 - responsible department for ensuring compliance for turning in the form -- HR Department #2 - responsible person for updating the org wide Orientation for Excellence Policy -- Director Staff Development4. By what date are you going to have the deficiency corrected? Plan of Action: By 8/28/13 - Dept job specific orientation checklist template developed. By 9/27/13 - Dept job specific orientation checklist Training class developed and Policy revisions completed. By 10/27/13 - Management staff education classes completed.	

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	staff member #P18, an LPN hired 05/31/06, had 46 line items/tasks left blank with no explanation as to why he/she was not oriented or signed off in those areas. The form was signed by a preceptor on 08/09/06. 7. At 1:50 PM on 07/10/13, staff member #A36 indicated the orientation forms should have been completed or documented if not applicable. He/she indicated the unit director reviewed new employees orientation packets at the 90 day evaluation and should ensure all of the training was complete.			

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S000362	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F) (d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following: 6) Ensure that the hospital does the following: (A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants. Based on documentation review, the facility failed to notify Indiana Organ Procurement Organization (IOPO) for 1 hospital death in 2012.	S000362	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Education of OB staff will occur on the definition of fetal death,	08/28/2013

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	Findings included: 1. Hospital Procurement Agreement with IOPO signed in 2007, Article H section 2a states, "Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the Hospital." 2. Schneck Medical Center Donation 2012 Statistics and Benchmarks report identified the hospital had 38 deaths in 2012 and only 37 of those 38 deaths were reported to IOPO.		signs of life and reporting of death to IOPO. Methods of education will be via email and at August 21, 2013 staff meeting. Schneck Medical Center will develop an algorithm of fetal gestation age and signs of life to determine if event is a fetal death, along with steps of reporting death. 2. How are you going to prevent the deficiency from recurring in the future? Recurrence will be prevented through education and adherence of processes implemented. 3. Who is going to be responsible for numbers 1 and 2 above? Director of Women & Children's services will be responsible for compliance. 4. By what date are you going to have the deficiency corrected? August 28, 2013	

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S000610	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (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: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, documentation review, and staff interview, the facility failed to ensure high-protein Enteral tube-feeding supplements were stored properly in the Dietary Department.	S000610	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The enteral feeding supplements were placed in a closed cabinet for storage on July 12, 2013. All enteral supplements are now stored in an enclosed cabinet. Schneck Medical Center placed all enteral ready to hang formulas in this enclosed cabinet and have	08/28/2013

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	Findings included: 1. At 3:30 PM on 7/8/2013, the Kitchen of the Dietary Department was observed storing Abbott Enteral Feeding supplements on wired shelves under florescent ceiling lights with carton's sides cut open exposing the two bottles of the carton to the fluorescent lighting. Loose assorted nutritional tube-feeding supplements were also observed stored on the cases. The department contained the following items that were observed stored in direct florescent lighting: 4 bottles Osmolite 1.2 cal; 4 bottles Jevity 1.5 cal; 3 bottles Glucerna 1.0 cal; and 6 bottles Jevity 1.0 cal. 2. The manufacturer Abbott product label of the assorted Enteral ready-to-eat nutritional supplements states, "Contain light sensitive nutrients." The manufacturer indicates artificial light degrades vitamins such as		labeled the outside "*Enteral Ready to Hang Storage. All Ready to Hang formulas are to be stored in closed cabinets away from light to retain maximum quality*." 2. How are you going to prevent the deficiency from recurring in the future? To prevent from reoccurring - process for storage was changed, staff educated on change. Schneck Medical Center placed all enteral ready to hang formulas in this enclosed cabinet and have labeled the outside "*Enteral Ready to Hang Storage. All Ready to Hang formulas are to be stored in closed cabinets away from light to retain maximum quality*." 3. Who is going to be responsible for numbers 1 and 2 above? Director and Manager of Nutrition Services will be responsible for compliance. 4. By what date are you going to have the deficiency corrected? August 28, 2013	

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	riboflavin (B2), B6, and vitamin A. Vitamins losses occur gradually at low light exposure and faster in bright light. The manufacturer states, "Store product in the shipper or store on covered shelves or in close cabinet prior to use." 3. At 3:45 PM on 7/8/2013, staff member #30 indicated the vendor had been in and told the staff the nutritional tube-feeding supplies need to be stored in a closed cabinet before they are used. The staff member has been looking for such a cabinet but has not found a cabinet yet.			

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S001014	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c) (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals. Based on observation and interview, the facility failed to properly monitor and store medication in two patient care areas (surgery and 4 North). Findings included: 1. During the tour of the surgical area at 10:20 AM on 07/09/13, accompanied by staff members #A13, A17, and A21, the following observations were made of the emergency malignant hyperthermia cart: A. Six of thirty-six vials of Dantrolene expired 06/2013. B. One of one 50 milliliter vial of Mannitol 25% expired 1 June 2013. C. One of one 14 gauge angiocath expired 09/2012. 2. At 10:25 AM on 07/09/13, staff member #A17 indicated pharmacy was responsible for checking the medication monthly and surgical staff should check the supplies on the cart.	S001014	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A pharmacy staff member will be responsible for monthly unit inspection of the OR malignant hyperthermia cart. Any drugs or biologicals in question were either replaced or disposed of immediately per OR Manager. 2. How are you going to prevent the deficiency from recurring in the future? Education will be provided to pharmacy staff for proper unit inspection of all areas. OR staff educated and a checklist for outdated items with nurse's signature will be placed on MH cart to be checked on a monthly basis. OR manager will check checklist for signatures each month. On 4N education will be	08/28/2013

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	3. During the tour of the 4 North patient unit at 1:20 PM on 07/09/13, accompanied by staff members #A13 and A24, a small bottle of Nitrostat tablets was observed stored in a cabinet with glucometer testing supplies in the medication/supply room. The bottle had a sticker which read "Do not use after", but there was no date or initials on the label. The bottle contained 22 tablets from an original 25 (per label). 4. At 1:25 PM on 07/09/13, staff member #A24 indicated the bottle should have been dated when opened if there was a sticker on it and also indicated it should not have been stored in the cabinet with glucometer supplies.		provided on proper storage and disposal of medications. (Attachment 3) 3. Who is going to be responsible for numbers 1 and 2 above? Director of Pharmacy, OR Manager, and 4N Director and Manager will be responsible for compliance. 4. By what date are you going to have the deficiency corrected? August 28, 2013	
S001118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation,	S001118	1. How are you going to correct the deficiency? If already	08/28/2013

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	documentation review, and staff interview, the facility failed to ensure all areas of the hospital were maintained in a safe, sanitary, and hazard-free condition for staff. Findings included: 1. At 9:30 AM on 7/10/2013, the Main Housekeeping Room was toured. The room was observed storing a large un-labeled white insecticide sprayer partially filled with a white liquid substance within it; a floor scrubber charging it's batteries; 5-gallons of assorted chemicals; gallons of chlorine bleach; etc. The room was observed with a wall mounted eye wash station with 2-32 ounce bottles of saline solution. Therefore, the wall mounted 2. Schneck Medical Center Eyewash Stations policy (last approved 11/2012) states, "In the event that an exposure to the eyes occurs, flushing the eyes is critical		corrected, include the steps taken and the date of correction. A self contained 1-gallon capacity eyewash station will be installed in the housekeeping room. Bleach and instrument cleaning bottles were removed immediately on 7/9/13 and stored in a proper location. The O2 tank was properly stored immediately during survey. 2. How are you going to prevent the deficiency from recurring in the future? Eyewash replacement cartridges will be maintained on a 180 day replacement cycle. Recurrence will be prevented by maintaining correct placement of station. Central Sterile Staff were educated regarding not storing cleaning bottles at hand washing sink. Education was provided to 3N staff on proper O2 tank storage on July 10, 2013. (Attachment 4) 3. Who is going to be responsible for numbers 1 and 2 above? Director of Facilities, Manager of SPD, and Director and Manager of 3N to be responsible for compliance. 4. By what date are you going to have the deficiency corrected? Eyewash station will be placed August 9, 2013. All others by August 28, 2013.	

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	to reduce the damage of infection risk cause by exposure." The policy defines wall mounted portable self contained eye wash stations. The temporary flush stations contain 2-32 ounce bottles for emergency flushing where fixed eye wash stations are not readily available. 3. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, 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			

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	acid or caustic is used, the unit should be immediately adjacent to the hazard." ANSI also determined that 16-ounce bottle of saline solution can only provide approximately 2-minutes of eye wash flushing. 4. At 9:30 AM on 7/10/2013, staff member #4 indicated the hospital does comply with OSHA standards for employee safety. The staff member confirms the 2-32 ounce bottles mounted on the wall will not comply with 15-minutes of emergency eye flushing. 5. During the tour of the central sterile area at 10:45 AM on 07/09/13, accompanied by staff members #A13, A16, and A17, the small handwashing sink was observed with 3 spray bottles of instrument lubricant and 1 spray bottle of bleach disinfectant stored on the edge behind the faucet handles. 6. At 10:50 AM on 07/09/13,			

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	staff member #A16 indicated instruments were sometimes sprayed with the lubricant at that handwashing sink and confirmed the possibility of clean hands being exposed to the chemicals at the sink. 7. During the tour of the 3 North med/supply room at 1:20 PM on 07/09/13, accompanied by staff members #A13 and A24, a filled oxygen cylinder was observed in the corner of the room, but not secured.			
S001162	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A) (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: (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule. Based on observation, document	S001162	1. How are you going to correct	08/28/2013

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	review and staff interview, the facility failed to comply with manufacturer recommendations for hot-holding temperature range for 1 of 1 Hydrocollator in the Rehabilitation Department. Findings included: 1. The Operation Manual instructions for the use and operation of the Schneck Medical Center off-site Rehabilitation Department Hydrocollator Chattanooga M-1 noted the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 166 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs. 2. The Schneck Medical Center off-site Rehabilitation Department 2013 Hydrocollator Temperature		the deficiency? If already corrected, include the steps taken and the date of correction. New temperature log with correct temp initiated August 5, 2013. New policy with correct temperatures listed. (Attachments 5 and 6) 2. How are you going to prevent the deficiency from recurring in the future? Through implementation of new policy and tracking method. 3. Who is going to be responsible for numbers 1 and 2 above? Director and Manager of Rehab 4. By what date are you going to have the deficiency corrected? August 28, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/10/2013
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	Log revealed the the temperatures are monitored once a week. The Schneck Medical Center off-site Rehabilitation Department Hydrocollator Temperature Log stated, "150 - 160 degrees Fahrenheit." The temperature log notes checked marks once per week for the year 2013. Therefore, the log evidence the temperatures were never recorded above 160 degrees Fahrenheit.			

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S001172	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (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: (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: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on observation and staff interview, the facility failed to ensure hospital was utilizing a high-level disinfectant in a safe manner to guard against transmission of disease to patients, and health care workers. Findings included: 1. At 10:15 AM on 7/10/2013, the Radiology Department was toured. The department was observed with a high level disinfecting station in the soiled	S001172	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Director of Diagnostic Imaging will work with Director of Facilities on where to move GUS system. 2. How are you going to prevent the deficiency from recurring in the future? Recurrence will be prevented by selecting proper location. 3. Who is going to be responsible for numbers 1 and 2 above? Director of Diagnostic Imaging and Director of Facilities 4. By what date are you going to have the deficiency corrected? Director of Diagnostic Imaging will work with Director of Facilities on where to move GUS system through	09/28/2013

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	utility room. The disinfecting agent in the room was MetriCide OPA. The room was storing white soiled linen/laundry hampers, 55-gallon drum with a red biohazard bag lining the container. Outside the room, the sign indicated the room was a soiled utility room. 2. At 10:40 AM on 7/10/2013, staff member #37 confirmed the room where the staff are disinfecting ultrasound probes from all areas of the hospital was a soiled utility room. The staff member confirmed the room was not the proper place to disinfect items.		August 28, 2013. System will be relocated to proper location between August 29, 2013 and September 28, 2013. The GUS system was relocated on August 9, 2013.	