

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151317	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/26/2013
NAME OF PROVIDER OR SUPPLIER  GREENE COUNTY GENERAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441		
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005061</p> <p>Dates: 03-25-13 through 03-26-13</p> <p>Surveyors: Billie Jo Fritch, RN, MBA, MSN Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratory Surveyor</p> <p>QA: claughlin 04/03/13</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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S000266	<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 review their bylaws at least triennially.</p> <p>Findings included:</p> <p>1. Review of the governing board bylaws on 3-25-13 and 3-26-13 lacked evidence the governing board had reviewed their bylaws at least triennially; documentation indicated the most recent review of the governing body bylaws was 11-14-08.</p> <p>2. An interview was conducted with B#1 on 3-26-13 at 1430 hours, who confirmed the governing board last documented a review of their bylaws on 11-14-08.</p>	S000266	<p>S266</p> <p>1. Greene County General Hospital Board of Trustees met on Tuesday April 16, 2013 and appointed a Bylaws Committee to review and update the Board of Trustees Bylaws. The Bylaws Committee will present recommendations to the Board at the May 21, 2013 Board meeting. At this time, the Board will approve updates to the Bylaws.</p> <p>2. The Bylaws revision will include a clause that the Bylaws will be updated triennially. The Bylaws will be added to our electronic policy database that will generate automatic reminders for updates.</p> <p>3. The Chief Operating Officer will be responsible for completion of items 1 and 2.</p> <p>4. The schedule for the corrective action will be as follows:</p> <ul style="list-style-type: none"> <li>· April 17, 2013 – Bylaws Committee Appointed</li> <li>· May 17, 2013– Bylaws Committee will have update prepared and ready for Board</li> </ul>	05/21/2013	

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			approval · May 21, 2013 – Updates will be presented to Board for approval	

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S000308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the facility failed to ensure employees had documentation of orientation to the hospital and to their specific departments for 15 of 20 (F#1, F#4, F#5, F#6, F#7, F#8, F#10, K#1, K#2, K#3, K#4, K#5, K#6 and K#10) personnel files reviewed.</p> <p>Findings included:</p> <p>1. Review of personnel files on 3-25-13 indicated the following:</p> <p>a. F#1, hired 10-8-90, lacked documentation of orientation to the hospital or department specific orientation.</p> <p>b. F#4, hired 1-29-08, lacked documentation of department specific orientation.</p> <p>c. F#5, hired 2-26-06, lacked</p>	S000308	<p>Tag S308</p> <p>1. General Hospital and Department specific orientation is required for each new hospital employee, at time of hire. In December, HR began auditing personnel files for federal compliance. As a part of the ISDH survey, HR became aware of the ISDH requirements for personnel files and has developed a new audit tool including these requirements. This audit form is being included in the front of each personnel file. In addition, a departmental orientation form was developed and provided to each department head; each department head is meeting with each employee to go through the departmental orientation checklist and each employee is having one completed and included in their personnel file. Also, HR is now</p>	07/24/2013			

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	<p>documentation of orientation to the hospital or department specific orientation.</p> <p>d. F#6, hired 11-21-77, lacked documentation of orientation to the hospital or department specific orientation.</p> <p>e. F#7, hired 2-16-12, lacked documentation of department specific orientation.</p> <p>f. F#8, hired 8-19-12, lacked documentation of orientation to the hospital or department specific orientation.</p> <p>g. F#10, hired 7-1-99, lacked documentation of department specific orientation.</p> <p>h. K#1, hired 11-2/98, lacked documentation of department specific orientation.</p> <p>i. K#2, hired 7/23/00, lacked documentation of orientation to the hospital or department specific orientation.</p> <p>j. K#3, hired 8/25/09, lacked documentation of orientation to the hospital or department specific orientation.</p> <p>k. K#4, hired 4/12/12, lacked documentation of department specific orientation.</p> <p>l. K#5, hired 5/10/93, lacked documentation of department specific orientation.</p>		<p>conducting the first portion of new employee orientation and the New Employee Orientation checklist is being collected by Human Resources personnel and immediately being placed in the employee's personnel file.</p> <p>2. For the first time in hospital history, there is a Human Resources Department. The collection and filing of this information will now remain a responsibility of HR. HR will continually monitor and review files to ensure policy and regulatory compliance using the audit tool described above.</p> <p>3. Human Resources personnel are responsible for auditing all employee files and ensuring that each file has the documents required by the State of Indiana.</p> <p>4. The audit tool was developed and auditing of each personnel file began on March 28, 2013. It is anticipated that the audit to determine what documents are missing will conclude May 25, 2013. After our audit, we will ensure file deficiencies are corrected within 60 days of the audit, or by July 24, 2013.</p>	

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	<p>m. K#6, hired 8/11/03, lacked documentation of department specific orientation.</p> <p>n. K#8, hired 8-19-12, lacked documentation of orientation to the hospital specific orientation.</p> <p>1. K#10, hired 8/13/98, lacked documentation of department specific orientation.</p> <p>2. The facility policy titled NEW EMPLOYEE ORIENTATION, last revision 2/09 was reviewed on 3-26-13 and indicated the following: Every full time, part time, or prn employee will attend the general orientation program.</p> <p>3. An interview was conducted on 3-26-13 with B#12 at 1350 hours and confirmed the hospital requires orientation of all employees to the hospital and department specific orientation to their department and specific duties; B#12 confirmed the personnel file of F#1, hired 10-8-90, lacked documentation of orientation to the hospital or department specific orientation; F#4, hired 1-29-08, lacked documentation of department specific orientation; F#5, hired 2-26-06, lacked documentation of orientation to the hospital or department specific orientation; F#6, hired 11-21-77, lacked documentation of orientation to the</p>			

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	<p>hospital or department specific orientation; F#7, hired 2-16-12, lacked documentation of department specific orientation; F#8, hired 8-19-12, lacked documentation of orientation to the hospital or department specific orientation, K#1, hired 11-2/98, lacked documentation of department specific orientation, K#2, hired 7/23/00, lacked documentation of orientation to the hospital or department specific orientation, K#3, hired 8/25/09, lacked documentation of orientation to the hospital or department specific orientation.</p> <p>K#4, hired 4/12/12, lacked documentation of department specific orientation, K#5, hired 5/10/93, lacked documentation of department specific orientation, K#6, hired 8/11/03, lacked documentation of department specific orientation, K#8, hired 8-19-12, lacked documentation of orientation to the hospital specific orientation, and K#10, hired 8/13/98, lacked documentation of department specific orientation.</p>			

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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 document review and interview, the facility failed to provide documentation of annual performance evaluations for 9 of 20 (F#1, F#4, F#7, F#8, F#10, Z#1, Z#2, Z#3, and Z#5 ) personnel files reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of nine personnel files on 3-25-13 lacked documented evidence of current annual performance evaluations for F#1, F#4, F#7, F#8, F#10, Z#1, Z#2, Z#3, and Z#5.</li> <li>An interview was conducted on 3-26-13 with B#12 at 1350 hours who confirmed all employees are to receive an annual performance evaluation; B#12</li> </ol>	S000312	<p>Tag S312</p> <ol style="list-style-type: none"> <li>Annual performance evaluations based on job descriptions, are required for each employee of the hospital. Human Resources developed a new comprehensive performance evaluation form to be completed for each hospital employee. In addition, annual performance evaluations are being changed to occur for each employee on their anniversary date; this will ensure managers of bigger departments with large numbers of employees will have the time and ability to conduct meaningful performance evaluations. As indicated in Tag S308, the personnel files are currently being audited and any employee, who does not have a performance evaluation as of their anniversary date, will be receiving</li> </ol>	06/25/2013			

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	confirmed the personnel files of F#1, F#4, F#7, F#8, F#10, Z#1, Z#2, Z#3 and Z#5 lacked documented evidence of current annual performance evaluations.		<p>one. Human Resources has also added an HR module to the hospital Electronic Records program (CPSI). This module will be used to help electronically track performance evaluation due dates.</p> <p>2. Human Resources will be tracking performance evaluation due dates using a newly added Human Resources electronic module. In addition, HR will be using the audit system explained in Tag S308 to ensure policy compliance.</p> <p>3. Human Resources personnel will be responsible to ensure policy compliance.</p> <p>4. Personnel files are due to be completely audited by May 25, 2013, at which time, HR will be contacting department heads/managers with the names of those employees who need to have the performance review conducted. We will allow those department heads/managers 30 days to get the performance evaluations written and delivered utilizing the new evaluation tool; this would mean they are in personnel files by no later than June 25, 2013.</p>		

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S000330	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review and interview, the facility failed to follow their established policy related to tuberculosis screening for 2 of 10 (F#8 and F#9) personnel health files reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of personnel health files on 3-25-13 lacked documented evidence that F#8 and F#9 had completed the annual QUESTIONNAIRE FOR TB SYMPTOMS as required by facility policy.</li> <li>Review of the facility policy titled</li> </ol>	S000330	<p>Tag S330</p> <ol style="list-style-type: none"> <li>Employee Health files will be audited for the annual questionnaire for TB symptoms. Missing questionnaires will be completed and placed in files.</li> <li>A spreadsheet will be created with all employees and the required documentation. All annual documentation will be updated within the employee's birth month and placed in the files. New employees will added at the time of hire and terminated employees will be removed when notified of term date.</li> <li>The Employee Health Nurse is responsible for ensuring ongoing</li> </ol>	05/25/2013	

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	<p><b>EMPLOYEE HEALTH EXAMINATION, IMMUNIZATION AND SURVEILLANCE on 3-26-13</b> indicated the following: Annual TB skin testing will no longer be done as per CDC guidelines; documented evidence of absence of symptoms for TB will be performed annually.</p> <p>3. Review of the <b>QUESTIONNAIRE FOR TB SYMPTOMS on 3-26-13</b> indicated the following: In lieu of an annual TB skin test, healthcare workers shall have documented evidence of absence of symptoms for TB at least annually.</p> <p>4. An interview was conducted with B#11 on 3-26-13 at 1415 hours who confirmed that the personnel health files of F#8 and F#9 lacked evidence they had completed the TB questionnaire that is required by facility policy.</p>		<p>compliance.</p> <p>4. Files will be audited and missing forms obtained by April 25, 2013. Excel Spreadsheet will be created and used by May 25, 2013.</p>		

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S000332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</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>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and interview, the facility failed to ensure documentation of annual competencies in infection control training, job competencies, and fire/life safety for 10 of 21 employee files reviewed (F#1, F#2, F#4, F#8, K#1, K#2, K#3, K#5, K#7 and N1).</p> <p>Findings included:</p> <p>1. Review of personnel files on 3-25-13 indicated the following:</p> <p>a. The personnel file of F#1 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training.</p> <p>b. The personnel file of F#2 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training.</p>	S000332	<p>Tag S332</p> <p>1. An electronic format for annual education was adopted by the facility January, 2013. This format contains infection control training, and fire/life safety training. Each hospital employee has an individual account and sign on to complete the required training modules. New employees will complete the training during orientation and current employees have until May 25, 2013 to complete the assigned modules.</p> <p>Staff competence to preform job responsibilities is assessed, demonstrated and maintained. A minimum of two competence indicators will be provided by each department head. Critical skills and behaviors will be based on high risk, low volume, problematic, and/or</p>	05/25/2013

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	<p>c. The personnel file of F#4 lacked documented evidence of annual infection control or fire/life safety training.</p> <p>d. The personnel file of B#8 lacked documented evidence of annual job specific competencies, infection control training, and fire/life safety training.</p> <p>e. The personnel file of Z#1 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training.</p> <p>f. The personnel file of Z#2 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training.</p> <p>g. The personnel file of Z#3 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training.</p> <p>h. The personnel file of Z#5 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training.</p> <p>i. The personnel file of Z#7 lacked documented evidence of annual infection control training, or fire/life safety training.</p> <p>j. The personnel file of N1 lacked documented evidence of infection control training and fire/life safety training.</p> <p>2. An interview was conducted on 3-26-13 at 1350 hours with B#12 who confirmed the personnel file of F#1</p>		<p>performance improvement. Competence will be documented through documentation in each employee file.</p> <p>2. The deficiency will be prevented from reoccurring by the auditing the completion report in annually and ensuring any employee delinquent will complete the missing modules. Department heads will receive an email each November of any delinquent modules. Competence indicators will be determined by December 1 for implementation on January 1 of each year by each manager.</p> <p>3. The Education Director is responsible for creating employee accounts and modules for training. Annually a delinquency module report will be reviewed for completeness. Department managers will be responsible for competence indicators.</p> <p>4. Assigned electronic training modules will be completed by May 25, 2013. Competence Indicators will be developed by May 25, 2013.</p>	

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	lacked documented evidence of annual job specific competencies, infection control training, and fire/life safety training; the personnel file of F#2 lacked documented evidence of annual job specific competencies, infection control training, and fire/life safety training; the personnel file of F#4 lacked documented evidence of annual infection control and fire/life safety training; the personnel file of B#8 lacked documented evidence of annual job specific competencies, infection control training, and fire/life safety training, the personnel file of Z#1 lacked documented evidence of annual job specific ompetencies, infection control training, or fire/life safety training, the personnel file of Z#2 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training, the personnel file of Z#3 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training, the personnel file of Z#5 lacked documented evidence of annual job specific competencies, infection control training, or fire/life safety training, the personnel file of Z#7 lacked documented evidence of annual infection control training, or fire/life safety training. B#12 confirmed all personnel files are to contain documentation of annual competencies,			

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	infection control training, and fire/life safety training.  3. Staff member #12 verified the personnel file information for staff member #N1 at 2:00 p.m. on 3/26/13.				

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S000566	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (e)(1)(2)</p> <p>(e) The chief executive officer, medical staff, and executive nurse shall do the following:</p> <p>(1) Be responsible for the implementation of successful corrective action plans in affected problem areas.</p> <p>(2) Provide for appropriate infection control input into plans for renovation and new construction to ensure awareness of federal, state, and local rules that affect infection control practices as well as plan for appropriate protection of patients and employees during construction or renovation.</p> <p>Based on observation, document review and staff interview, the facility failed to provide evidence that the infection control committee had input into renovation/construction of the facility and failed to develop and implement infection control polices addressing renovation.</p> <p>Findings include:</p> <p>1. Based on observation, the facility has major construction underway including, but not limited to, an addition to the emergency department.</p> <p>2. The infection control meeting minutes</p>	S000566	<p>Tag S 566</p> <p>1. The Infection Control Committee will be provided input into renovation/construction of the facility. This will be evidenced by: a line item will be added to the Infection Control Committee agenda. Policy and procedure will be developed to monitor current and future construction. Appropriate construction barriers will be added to the Materials Management area.</p> <p>2. The Infection Control Committee agenda now has an agenda item for construction to ensure monitoring at each meeting. Newly developed policy and procedures will be added to our</p>	05/25/2013	

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	<p>lacked evidence of the infection control committee involvement in the renovation/new construction. A meeting was held 7/31/12, 9/25/12, 12/11/12 and 1/22/13.</p> <p>3. Review of infection control policies and procedures indicated the facility had no infection control policy addressing renovation or new construction.</p> <p>4. Staff member #11 indicated the following in interview at 1:40 p.m. on 3/26/13: (A) The construction began a "few months ago". (B) He/she verified there was no information in the infection control meeting minutes verifying 5 the committee involvement in the construction. (C) He/she verified there was not an infection control policy addressing the construction.</p> <p>5. Staff member #1 indicated in interview at 1:50 p.m. on 3/26/13 that the renovation/construction began in October 2012.</p> <p>6. While touring the Materials Management Department on 3-26-13 at 1000 hours with B#1 and B#4, it was observed that a large area of the</p>		<p>electronic policy manual. The electronic policy database will generate automatic reminders to policy owners when review is required and will prevent missing any updates.</p> <p>3. The Infection Control Nurse will be responsible with input from the Infection Control Committee, Medical Staff, CEO, and CNO.</p> <p>4. Completion Date: Policy will be drafted by April 26, 2013. The policy will be presented to the Infection Control Committee for approval May 7, 2013 (next scheduled meeting). The barrier wall will be completed by April 25, 2013.</p>		

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	<p>department was under construction.</p> <p>There was no barrier in place to prevent the dust from the construction from entering the area where patient care supplies are stored, thus leaving a layer of dust on patient care supplies.</p> <p>7. An interview was conducted on 3-26-13 at 1340 hours with B#11 who confirmed there is construction in the Materials Management Department and no action has been taken to prevent dust from entering the area where patient care supplies are stored; B#11 confirmed there has been no discussion at the Infection Control Committee meetings to discuss barriers in the Materials Management Department to protect patient care supplies from being covered with construction dust; B#11 confirmed that no dust barriers has been in place to prevent dust from covering patient care supplies in the Materials Management Department.</p>				

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review, observation, and interview, the nurse executive failed to ensure the nursing department followed the fall risk policy for 2 of 3 patients, failed to ensure discharge instructions</p>	S000912	<p>Tag S 912</p> <p>1. Policy for Fall Prevention was effective February 1, 2006 and last reviewed on July 25, 2012. The policy will be reviewed by all nursing staff. LAMP Magnets will be</p>	05/25/2013

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	<p>were completed according to the physician orders for 1 of 3 pediatric patients, and allowed a student nurse to perform nursing duties for 1 of 1 student nurse.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of patients #22 and #24 medical records indicated both patients were identified as a high risk for falls.</li> <li>2. Review of pediatric patient #12 medical record indicated the following:               <ul style="list-style-type: none"> <li>(A) The physician ordered Albuterol 0.083% nebulizer treatments QID (four times a day) and an extra 2 times in a 24 hour period of time at the time of discharge (1/28/13).</li> <li>(B) The facility discharge instruction sheet signed by the patients parent indicated the patient was to use the Albuterol 0.083% nebulizer treatments 2 times a day "as needed".</li> </ul> </li> <li>3. Facility policy titled "Fall Prevention" last approved 7/31/12 stated under procedure: ".....LAMP (Look At Me Please) magnets will be placed on the door frames of patients on the medical/surgical unit who are at an increased risk of falling. This is to alert hospital staff that the patient is a high fall risk.</li> </ol>		<p>available for staff to place on the door frame of each patient identified at an increased risk for falling.</p> <p>Discharge instructions will be reviewed by another nursing staff member for accuracy.</p> <p>Student Nurse Job Description has been changed to remove IV starts from the job role.</p> <ol style="list-style-type: none"> <li>2. Fall Prevention-one day per week charts will be reviewed to identify patients with an increased risk for fall. Rooms will then be reviewed for the presence of the lamp magnet on the door. Measure of Success Threshold 100%.</li> </ol> <p>Discharge instructions-a committee consisting of the Discharge Planner, Department Manager, and staff will create an audit for discharge.</p> <p>Discharge planning will begin on admission and continue until the patient is released. Audits will be conducted randomly to ensure compliance and accuracy. This process will be adopted by Med-Surg as a performance improvement project for the remainder of 2013. Measure of Success Threshold 90%.</p> <p>All student nurses, managers, and supervisors have been notified student nurses are not permitted to start IV's.</p> <ol style="list-style-type: none"> <li>3. The Med/Surg manager will be responsible for implementation and audits of Fall Prevention. Utilization Review Manager will be</li> </ol>				

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	<p>4. Facility policy titled "Discharge Instruction Form" last approved on 7/30/12 stated "The nurse will complete a discharge instruction form for every medical/surgical patient at the time of release from the hospital. The discharge instruction form will be a summary of the discharge plans as they stand at the time the patient is actually dismissed with the patient's or family signature....."</p> <p>5. Review of staff member #N1 personnel file indicated the following: (A) He/she was hired and is currently a student nurse. (B) The file contained evidence that the student nurse performed five (5) I.V.s during the month of June 2012.</p> <p>6. During tour of the medical/surgical unit beginning at 10:25 a.m. on 3/26/13, it was observed that patients #22 and #24 did not have a magnet placed on their door frame per policy.</p> <p>7. RN #1 verified in interview at 10:50 a.m. on 3/26/13 that patients #22 and #24 were identified as a fall risk and there were no magnets on the door frames.</p> <p>8. Staff member #8 verified the closed medical record information beginning at 10:30 a.m. on 3/25/13 and indicated that</p>		<p>responsible for audits of discharge plans. CNO is responsible for Student Nurse Job Roles. 4. Fall Prevention Policy Review – completed May 25, 2013. Fall Prevention Audit to Begin-May 1, 2013 and will continue throughout 2013. Discharge Planning Team to meet and create the discharge audit by April 25, 2013. Discharge Planning PI to begin May 1, 2013 and continue the remainder of 2013. Student Nurse Role was changed March 26, 2013. Job Role updated April 1, 2013.</p>				

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	the discharge instruction sheet for patient #12 did not match the physicians orders.				

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on blood transfusion policy review, transfusion document chart reviews and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for one (Patient #8) of ten patients.</p> <p>Findings include:</p> <p>1. On 3/25/13 at 1300, review of the policy, "Blood Transfusions", approved 8/13/12, read: "Transfusion time at least 1 1/2-2 hours unless massive hemorrhage is reoccurring. No longer than 4 hours from check out time from the lab due to possibility of bacterial contamination and red cell hemolysis at room temperature."</p> <p>2. On 3/25/13 at 1300, review of one patient receiving blood units indicated one of these received-units did not have</p>	S000952	<p>S 952</p> <p>1. The deficiency is going to be corrected by having each staff authorized to transfuse blood complete an electronic education course and competency exam over transfusion policies and procedures.</p> <p>2. Recurrence will be prevented by implementing a revised process to improve the timeliness of blood transfusion record review and employee education. Blood bank staff will review records with the nurse.</p> <p>3. The Director of Education will be responsible for ensuring the education course and competency exams are completed. The Laboratory Manager is responsible for developing the revised procedure for review of blood transfusion records.</p> <p>4. The education module will be developed by April 25, 2013. Education and competency exams will be completed by May25, 2013.</p>	05/25/2013			

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	<p>complete documentation, per policy, on the Blood Transfusion Record form including: Patient #8 --Unit administered on 2/27/13 at 2215: The unit was released at 2200 from the blood bank and ended at 0215 which was at 4 hours and 15 minutes in lieu of 4 hours</p> <p>3. On 3/25/13 at 1300, staff member #9 indicated that the above-listed patient had received blood without benefit of complete documentation, per policy, as required.</p>		<p>The Laboratory Manager will draft the policy for blood transfusion record review by April 25, 2013. The Policy will be approved by the Laboratory Director by April 25, 2013 and implementation complete by May 25, 2013. Education on the revised procedures will be completed by May 25, 2013.</p>		

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S001162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(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.</p> <p>Based on observation and staff interview, the facility failed to ensure sufficient space was provided to store equipment and supplies for 1 surgery department.</p> <p>Findings include:</p> <p>1. During tour of the surgery department beginning at 11:00 a.m. on 3/26/13 the following was observed in the anesthesia workroom: (A) Numerous boxes and supplies stored within 4-5 inches of the ceiling all around the room. (B) Boxes of supplies, baskets, and containers stored directly on the floor. There was not space for the items on the shelving units provided.</p>	S001162	S1162 1. Supplies in the anesthesia work room have been minimized and reorganized to remove all supplies from the floor and reduce items on top shelves. Space does not currently exist to move the equipment located in the ICU area to the Surgery area. The hospital is currently undergoing construction and renovation. Plans have been revised to include two new storage areas to the Surgery department. This renovation is scheduled to be completed in May of 2014. Until this space is completed, the surgery staff will ensure that equipment stored in ICU is low frequency use equipment. 2. The Director of Surgery will monitor the storage space to ensure that supplies are properly stored and any equipment stored outside of the	05/30/2014	

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	<p>2. During tour of the intensive care unit (ICU) beginning at 12:00 p.m. on 3/26/13 numerous supply items were observed stored behind a curtain adjacent to patient rooms.</p> <p>3. Staff member #N2 identified the items stored behind the curtain in ICU as belonging to the surgery department.</p>		<p>Surgery Department is low frequency use equipment. This will be documented monthly by the Director of Surgery until the additional storage space is completed. 3. The Chief Operating Officer, will be responsible to ensure that the renovation plans include the additional storage space and to ensure the completion of this construction. The Director of Surgery, will be responsible to ensure that items are properly stored and to complete the regular monitoring described in item 2. 4. On March 28, 2013, new shelving was installed in the anesthesia workroom. All supplies were removed from the floor and supplies were minimized on upper shelves. Equipment in the ICU space was surveyed to determine that only low frequency items remain in this space. Any high frequency items were relocated to surgery department. On April 3, 2013, the Chief Operating Office and the Chief Nursing Officer, met with architects to revise construction plans to add storage space to the Surgery Department. On April 4, 2013, draft plans were provided. The architects are working with the construction project manager and hospital leadership to finalize plans. Meeting is scheduled for May 1, 2013 with the hospital leadership, construction project management, and architects to discuss construction progress.</p>		

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			This is a standing biweekly meeting that will occur until construction is complete. When construction is complete (approximately May 2014), all storage spaces in the Surgery Department will be reorganized to allow for all supplies and equipment used by surgery staff to be properly stored in the surgery department.	