

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2013
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NAME OF PROVIDER OR SUPPLIER SCOTT MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1451 N GARDNER ST SCOTTSBURG, IN 47170
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 8/12/2013 through 8/14/2013</p> <p>Facility Number: 004778</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 08/20/13</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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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on documentation review and staff interview, the facility failed to have an ongoing process of monitoring and evaluating of 23 services as part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Scott Memorial Hospital Quality Improvement and Patient Safety 2013 Plan implements all services with direct or indirect impact on patient care quality shall be reviewed under the</p>	S000406	How are you going to correct the deficiency? Scott Memorial Hospital Quality Improvement and Patient Safety Plan will be reviewed with directors of all service areas. Each service area will work with the Director of Quality to establish quality indicators, with set goals / benchmarks that will be monitored throughout the year. These quality indicators will be reported to the Quality Director on a quarterly basis. Quality data, including thresholds, and any applicable action plans will be presented to the Quality and Patient Safety Committee. How are you going to prevent the deficiency from recurring in the future? Set clear expectations regarding selection of quality indicators, ongoing monitoring and data collection, data analysis, reporting requirements,	09/04/2013

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	<p>quality improvement program. Each multidisciplinary team shall develop a plan for improving quality of a process including the goal and target. Each team shall evaluate the plan then the team shall evaluate the data to determine the effectiveness and make recommendations to change based on results of the data. The hospital multidisciplinary teams would provide results from the data of the indicators that were monitored and report it to the Quality and Patient Safety Committee. The Quality and Patient Safety Committee was an oversight committee to provide for direction and guidance for quality and safety of the facility.</p> <p>2. Seven services collected data but did not have a goal or target they were to achieve: Blood Bank, Central Sterile, Medical Records, Orthopedic Surgery, Renal Dialysis, Social Services, and Utilization Review. The 7 services were discussed in their</p>		<p>identification of correction actions and evaluation of corrective actions. Set clear consequence of not carrying out process of quality assessment. Who is going to be responsible for numbers 1 and 2? It will be the duty of the director responsible for each service area to work together with the quality director to design a system of measures that will give meaningful insight into the quality of the services provided and that include thresholds for corrective action. Each department director will oversee the accurate and assiduous collection of data identified as relevant to the measures selected to be monitored. Each department director will provide a quarterly report to the hospital quality director giving the performance data for that quarter and indicating whether a threshold was passed. When a threshold is not met, the department director will provide an action plan to the hospital quality director contemporaneously with submission of the quarterly report, which will be presented at the quarterly Quality and Patient Safety Council meeting. The quality director will be responsible for preparing an annual quality improvement plan which will be presented to the hospital's chief executive officer before January 31 of the calendar year in which it is to be implemented. By what date are you going to have the</p>		

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	<p>departmental meetings and were not forwarded to the Quality and Patient Safety Committee.</p> <p>3. The hospital failed to ensure 16 services as part of its comprehensive quality assessment and improvement (QA&I) program: alcohol/Drug, CT Scanner, Endoscopy, Infection Control, Infusion Therapy, MRI, Obstetrics, Outpatient Services, Pediatrics, Pharmacy, PICC Line, Radiology-Teleradiology, Surgical Services Inpatient and outpatient, Tissue Transplant, and Ultrasound.</p> <p>4. At 11:00 AM on 8/14/2013, staff member #2 indicated he/she was in charge of the Quality Improvement Program. The staff member indicated the departments monitor their own quality assurance and it is common that the departments do not share the information to the Quality and Patient Safety Committee. The staff member indicated when</p>		<p>deficiency corrected? Review of the Quality Improvement and Patient Safety Plan will take place at the Quality and Patient Safety Committee meeting on September 11, 2013. Directors of each service area have worked with the quality director to identify quality indicators and set goals / benchmarks. This is completed as of 9-4-2013. The data from the contracted dialysis company provides it to the CNO and it was never shared to staff member #2.</p> <p>How are you going to correct the deficiency? All contracted services will be reviewed annually for verification of quality indicator monitoring against established thresholds. How are you going to prevent the deficiency from recurring in the future? Set clear expectation regarding quality indicators and thresholds between Scott Memorial Hospital and all contracted services. Set clear consequence of not carrying out quality measurement and reporting. Who is going to be responsible for numbers 1 and 2? CEO, CNO and Director of Quality. By what date are you going to have a deficiency corrected? All contracts will be reviewed by October 18, 2013. Contract data will be shared with Quality and Patient Safety Committee.</p>				

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	<p>he/she tried to retrieve the QA documentation from the departments, several of the departments were just recording data and did not evaluate from the data to meet a set goal. The data from the contracted dialysis company provides it to the CNO and it was never shared to staff member #2 (Director of Quality). The staff member confirmed that 16 hospital services are not being monitored or evaluated by the facility.</p>			
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S000408	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).</p> <p>Based on documentation review and staff interview, the facility failed to evaluate Discharge Planning as part of the patient care functions.</p> <p>Findings included:</p> <p>1. Scott Memorial Hospital Quality and Patient Safety Council committee minutes were provided for the previous 4 quarters by staff</p>	S000408	How are you going to correct the deficiency?Discharge Planning will establish quality indicators, with set goals / benchmarks that will be monitored throughout the year. These quality indicators will be reported to the quality director on a quarterly basis. Quality data, including thresholds, and any applicable action plans will be presented to the Quality and Patient Safety Committee. How are you going to prevent the deficiency from recurring in the future? Set clear expectation regarding selection of quality indicator, ongoing monitoring and data collection, data analysis,	09/11/2013			

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S000554	<p>member #2. The data and minutes provided by staff member #3 did not identify that Discharge Planning functions were being evaluated.</p> <p>2. At 1:30 PM on 8/613/2013, staff member #2 confirmed Discharge Planning function was not being evaluated by the Quality and Patient Safety Council committee.</p> <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, documentation review, and staff interview, the facility failed to ensure 2 of 2 Laboratory Technicians wore lab coats while working in the Laboratory and failed to ensure clean supplies and equipment were protected from</p>	S000554	<p>reporting requirements, identification of correction plans and evaluation of corrective actions. Set clear consequence of not carrying out process of quality monitoring and reporting. Who is going to be responsible for numbers 1 and 2? Director of Quality. By what date are you going to have the deficiency corrected? Quality indicators with thresholds have been identified. Data will be shared at the Quality and Patient Safety Committee on September 11, 2013.</p> <p>How are you going to correct the deficiency? Staff education regarding Policy #SAF 12.0020 was conducted. All employees signed an acknowledgement that they were trained on the proper use of lab coats within the laboratory. How are you going to prevent the deficiency from recurring in the future? Set clear expectation regarding adherence</p>	09/13/2013

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	<p>contamination in three patient care areas (Emergency Department, Surgical Department, and Medical/Surgical Unit).</p> <p>Findings included:</p> <p>1. Scott Memorial Hospital Universal Precautions Policy #SAF 12.0020 (Last approved 3/2008) states, "All persons working in a technical are must wear a long sleeved full-strength lab coat. Fluid imperible smocka are to be worn in the lab while performing any procedures which could result in accidental contact wit blood, body fluids, or any other potentially harmful or infectious materials."</p> <p>2. At 2:30 PM on 8/13/2013, the Laboratory Department was toured. The department was observed with two staff member working on complex procedures and not just working on paperwork, computer work, etc. Neither staff member was</p>		<p>to all department policies.Set clear consequence of not abiding by hospital policies.Review the SMH Human Resources Disciplinary Policy.Who is going to be responsible for numbers 1 and 2?Director of Laboratory By what date are you going to have the deficiency corrected? Completed as of September 4, 2013 Plan of Correction How are you going to correct the deficiency?Corrugated cardboard boxes will no longer be used for the delivery or storage of supplies to, or storage in, clean supply rooms or patient care areas.How are you going to prevent the deficiency from recurring in the future?Plastic totes have been ordered and received in Materials Management to be used for delivery of supplies.Clear expectations have been set for Materials Management personnel to not allow any corrugated cardboard to be used for delivery of supplies to clean supply rooms or patient care areas.All personnel will be educated and instructed to immediately remove any corrugated cardboard found in clean supply rooms or patient care areas. If the problem recurs, all staff will be instructed to notify their Director, Controller, or Quality Director,Who is going to be responsible for numbers 1 and 2?ControllerBy what date are you going to have the deficiency corrected? September 13, 2013</p>		

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	<p>observed wearing their required lab coats.</p> <p>3. At 2:30 PM on 8/13/2013, staff member #18 indicated he/she took her lab coat off when they entered another room in the department because it was 15 degrees Fahrenheit higher in temperature and forgot to put on the lab coat when entering the main area of the lab. The staff member confirmed that both of the lab associates in the Laboratory Department should have been wearing their lab coats which were hanging on hooks in the departments.</p> <p>4. At 1:15 PM on 8/14/2013, staff member #17 indicated that all staff that work in the Laboratory Department are required to wear lab coats when working on lab test or procedures.</p> <p>5. During the tour of the Emergency Department at 1:20 PM on 08/12/13, accompanied by staff members #A1, A2, and A10,</p>						

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	<p>several cardboard boxes of supplies were observed stored in the clean supply room, alongside unprotected clean equipment and supplies.</p> <p>6. At 1:25 PM on 08/12/13, staff member #A10 confirmed some of the boxes arrived directly to the room from the outside and were not boxes removed from an outer wrap.</p> <p>7. During the tour of the Surgical Department at 2:40 PM on 08/12/13, accompanied by staff members #A2 and A14, four cardboard boxes of intravenous bags were observed stored on a cart in the clean supply room, alongside unprotected clean equipment and supplies.</p> <p>8. At 2:45 PM on 08/12/13, staff member #A14 confirmed the boxes came from the outside and were not boxes removed from an outer wrap.</p>			

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S000596	<p>9. During the tour of the Medical/Surgical Unit at 3:15 PM on 08/12/13, accompanied by staff members #A1, A2 and A16, two cardboard boxes of intravenous bags were observed stored in the clean supply room, alongside unprotected clean equipment and supplies.</p> <p>10. At 3:20 PM on 08/12/13, staff member #A16 confirmed the boxes came from the outside and were not boxes removed from an outer wrap.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p>			

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	<p>Based on observation, policy and procedure review, manufacturer's directions, and interview, the infection control committee failed to ensure the appropriate rinsing procedures for high level disinfection were followed in the decontamination room and in the Women's Imaging Department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During the tour of the surgical area at 3:00 PM on 08/12/13, accompanied by staff members #A1, A12, and A14, a container of Cidex OPA for high level disinfection was observed in the decontamination room. 2. At 3:10 PM on 08/12/13, staff member #A12 indicated some scopes and cardiac instruments were soaked in the disinfectant, rinsed under running water in the sink, and immediately dried. He/she indicated he/she did not rinse the instruments for any specified time or for 3 separate rinses. 3. During the tour of the Women's Imaging Department at 11:15 AM on 08/14/13, accompanied by staff member #A25, a Cidex OPA wall mounted rinsing system was observed for use with the vaginal ultrasound probes. 	S000596	<p>How are you going to correct the deficiency? Scott Memorial policy "Cidex OPA and GUS station" has been revised per manufacturer recommendations. The policy will be maintained within the Infection Control Manual. Staff members of Ultrasound Department and Surgery Department have been inserviced on the proper rinsing technique, per manufacturer recommendations. Representative from Johnson & Johnson will be here to review the policy and make further recommendations on September 12, 2013. How are you going to prevent the deficiency from recurring in the future? The infection control nurse will have ongoing monitoring of staff use of Cidex OPA. Who is going to be responsible for numbers 1 and 2? Director of Ultrasound and Director of Surgery By what date are you going to have the deficiency corrected? Completion date September 5, 2013.</p>	09/05/2013			

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	<p>4. At 11:20 AM on 08/14/13, staff member #A25 indicated the vaginal probe was immersed in the Cidex OPA for 12 minutes, placed in the next tube of fresh water for 2 minutes, and placed in fresh water again for 2 minutes. The rinsing tube contained approximately 32 ounces of water. Staff member #A25 confirmed 3 rinses with copious amounts of fresh water were not performed.</p> <p>5. The facility policy "Cidex OPA and GUS Station", last reviewed June 29, 2011, indicated, "The probe should be placed in 3 separate containers of potable water for approximately 1 minute each to rinse the remaining Cidex from the probe and discard after each use per Cidex Manufacturer recommendation of Advanced Sterilization Products."</p> <p>6. The manufacturer's directions for Cidex OPA indicated, "B. Rinsing Procedure: Following removal from Cidex OPA Solution, thoroughly rinse the medical device by immersing it completely in a large volume (e.g. 2 gallons) of water. Use sterile water unless potable water is acceptable. Keep the device totally immersed for a minimum of 1 minute in duration, unless a longer time is specified by the reusable</p>						

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	<p>device manufacturer. Manually flush all lumens with large volumes (not less than 100 milliliters) of rinse water unless otherwise noted by the device manufacturer. Remove the device and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing or any other purpose. Repeat the procedure TWO (2) additional times, for a total of THREE (3) RINSES, with large volumes of fresh water to remove Cidex OPA Solution residues. Residues may cause serious side effects. SEE WARNINGS. THREE (3) SEPARATE, LARGE VOLUME WATER IMMERSION RINSES ARE REQUIRED."</p> <p>7. At 4:15 PM on 08/13/13, staff member #A1 indicated even though the Cidex policy referred to the ultrasound probes, it was the only facility policy for the use of Cidex.</p>			

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S000610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation and staff interview, the facility failed to ensure patient food was not stored in a staff refrigerator of the Frazier Rehab Center.</p> <p>Findings included:</p>	S000610	How are you going to correct the deficiency?The Director of Plant Management has obtained a dormitory sized refrigerator to store food items for use by therapy patients only. How are you going to prevent the deficiency from recurring in the future?Set clear expectation regarding guidelines on storage of employee food in patient refrigerators.Set clear	08/29/2013			

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S000930	<p>1. At 10:30 AM on 8/14/2013, the Frazier Rehab Center was toured. A refrigerator marked "Employee Use Only" was observed storing 3 cases of food items mixed in with staff food. The cases of food items included Nectar and Honey.</p> <p>2. At 10:45 AM on 8/14/2013, staff member #21 indicated the cases contained food for speech therapy. The staff confirmed the three cases of patient food items were stored in the staff refrigerator.</p> <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. Based on medical record review, standard of practice, and interview, the nurse executive failed to ensure assessments were done according to standard of practice for 1 of 2 pediatric patients (#N19) and failed to ensure</p>	S000930	<p>consequence of not abiding by infection control policies. Who is going to be responsible for numbers 1 and 2? The Rehab Services Director will be responsible for daily temperature checks and content of the refrigerator. By what date are you going to have the deficiency corrected? Completion date August 29, 2013</p> <p>How are you going to correct the deficiency? The clinical informatics nurse made the neurologic check queries in Meditech required fields. The hospital has changed all queries on the neurological exam to be required fields. Education will be</p>	10/13/2013	

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	<p>physician's orders were carried out for 1 of 2 pediatric patients (#N20) on the medical/surgical unit.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The medical record for patient #N19, a 23 month old admitted 06/10/13 for dehydration, lacked documentation of a head circumference measurement with the admission assessment. 2. At 4:00 PM on 08/13/13, staff members #A1 and A11 agreed that a head circumference measurement was standard of practice for pediatric patients. 3. The medical record for patient #N20, a one year old admitted for observation on 06/27/13 with a diagnosis of new onset seizures, indicated physician orders for seizure precautions and neurological checks every 2 hours. The medical record lacked any documentation of seizure precautions being implemented. The record indicated documentation of neuro checks at 0430 on 06/28/13, incomplete checks at 0603 on 06/28/13 with a nursing notation of "Unable to look at pupils, child crying and rolling around in crib", and incomplete checks at 0800 on 06/28/13, but with no explanation. 		<p>provided to all registered nurses on the medical surgical unit, in regards to pediatric neurological assessment, expectations in regards to completing this assessment and consequences of failing to assess and document. How are you going to prevent the deficiency from recurring in the future?Set clear expectation regarding physician orders and documenting the implementation of the orders.Set clear consequence of not carrying out and documenting physician orders.Review SMH Human Resources Disciplinary PolicyFor the next 6 months, the Director of Med/Surg will review all patient charts under the age of 3 on the medical / surgical unit, to ensure 100% compliance of neurological assessments are completed as ordered by the physician. A spot check will be completed after the initial 6 months and as needed until compliance is met.Information on the monitoring will be shared with the Quality and Patient Safety Committee. Monitoring includes the actual performance, goal of 100%, and consequence of steps if not met.Who is going to be responsible for numbers 1 and 2? CNO and Director of Med/Surg By what date are you going to have the deficiency corrected? Completion date of October 13, 2013 Plan of Correction How are you going to correct the deficiency?The</p>				

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	4. At 4:00 PM on 08/13/13, staff members #A1 and A11 confirmed the medical record findings and also confirmed documentation was lacking to ensure the physician's orders were implemented.		clinical informatics nurse built two rules in Meditech: One rule required the head circumference query for all patients under the age of 3. The other rule suppresses the head circumference query for patients 3 and over. The CNO clarified thru policy and education that a head circumference assessment is required for all patients under the age of 3. A head circumference query exists in the current electronic medical record. The rules created by the clinical informatics nurse will automatically place the head circumference assessment on the appropriate population. Utilizing the Lippincott Manual for Nursing Practice, the CNO developed a policy clarifying that documenting a head circumference is the standard of practice for all patients under the age of 3. The Head Circumference Policy was approved by the Medical Executive Committee on September 6, 2013. The nursing staff will be educated on the new head circumference policy, expectations as to abiding by policies and procedures and consequences if not followed. A pediatric head circumference competency will be completed for all registered nurses working on the medical surgical unit. How are you going to prevent the deficiency from recurring in the future? Set clear expectation regarding physician orders and		

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			documenting the implementation of the orders.Set clear consequence of not carrying out and documenting physician orders.Review SMH Human Resources Disciplinary PolicyFor the next 6 months, the Director of medical surgical will review all patient charts under the age of 3 on the medical surgical unit to ensure 100% of the head circumferences are documented. A spot check will be completed after the initial 6 months and as needed until compliance is met.Information on the monitoring will be shared with the Quality and Patient Safety Committee. Monitoring includes the actual performance, goal of 100%, and consequence steps if not met. Who is going to be responsible for numbers 1 and 2? CNO and Director of Med/Surg By what date are you going to have the deficiency corrected? Completion date of October 13, 2013 Plan of Correction How are you going to correct the deficiency?Nursing staff will be educated on the importance of documenting seizure precautions.A review of client care delivered to patients with diagnoses of cerebral effects was completed to assess for documentation of seizure precautions. Information on the review will be used in the staff training and re-education.Nursing staff will be educated on documenting seizure precautions.	

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			The staff will be educated on ordering the seizure precautions in Meditech, expectations of accurate assessment and documentation, and consequences. Seizure precautions assessment will be built to allow staff to document what precautions were taken (padded side rails, side rails up, bed in low position, airway at bedside, suction /oxygen delivery device at bedside, and saline lock in place. How are you going to prevent the deficiency from recurring in the future? Set clear expectation regarding physician orders and documenting the implementation of the orders. Set clear consequence of not carrying out and documenting physician orders. Review SMH Human Resources Disciplinary Policy A monthly, for three months, random medical record review of patients having seizure precautions ordered to ensure the staff is documenting the implementation of seizure precautions per physician order. Spot check will be completed in six month intervals and as needed until compliance is met. Information on the monitoring will be shared with the Quality and Patient Safety Committee. Monitoring includes the actual performance, goal of 100%, and consequence steps if not met. Who is going to be responsible for numbers 1 and 2? CNO and Director of Med/SurgBy	

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S001028	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</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>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on observation and interview, the facility failed to ensure all medications were secured from unauthorized access in the surgical area.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the Endoscopy Room at 2:50 PM on 08/12/13, accompanied by staff members #A2 and A14, the anesthesia cart containing a tray of medications was observed unlocked and easily accessible. The room was dark and cases were completed for the day. During the tour of the Operating 	S001028	<p>what date are you going to have the deficiency corrected? Completion date of September 13, 2013</p> <p>How are you going to correct the deficiency?An external locking system has been added to both anesthesia carts to allow increased security and increased awareness of unlocked carts. How are you going to prevent the deficiency from recurring in the future?Set clear expectation regarding security and authorized access of all drug storage areas.Set clear consequence of not carrying out appropriate security measures of all drug storage areas.Review SMH Human Resources Disciplinary PolicyFor the next 3 months, the Director of Surgery will monitor the locking of anesthesia carts at the end of surgical procedures. Information on the monitoring will</p>	09/03/2013	

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S001118	<p>Suite #3 at 2:55 PM on 08/12/13, accompanied by staff members #A2 and A14, the anesthesia cart containing a tray of medications was observed unlocked and easily accessible. The room was dark and cases were completed for the day.</p> <p>3. At 3:00 PM on 08/12/13, staff member #A14 indicated the rooms were not in use and indicated the circulator should have locked the carts after the last case was finished. He/she confirmed the housekeeping staff and maintenance had access to the rooms.</p> <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 staff interview, the facility failed to ensure the outside infectious waste storage area was secured</p>	S001118	<p>be shared with the Quality and Patient Safety Committee. Monitoring includes the actual performance, goal of 100%, and consequence of steps if not met. Who is going to be responsible for numbers 1 and 2? Director of Surgery By what date are you going to have the deficiency corrected? Locks have been installed and Director is currently monitoring</p> <p>How are you going to correct the deficiency? The outside infectious waste storage area has been treated for rodents. Steritech currently inspects and treats on a monthly basis. A completed work</p>	09/13/2013			

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	<p>from tampering, rodent, or insect control and failed to properly store clean pulse oximeters in a sanitary manner in the Cardio Respiratory Department equipment store room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 1:14 PM on 8/13/2013, the outside infectious waste storage area was inspected. The outside chain link cage area is in view of the parking lot. The holes of the chain link fence have a 2 inch opening. The chain link fence is only 8 feet tall with approximate 2 feet open area from the fence to the ceiling of the infectious waste storage. Within the storage area was assorted filled red biohazard waste receptacles. The caged-in area was not completely secured from outside tampering and infestation of insects or rodents. At 2:16 PM on 8/13/2013, it was observed that the garbage bags were made from polyethylene polymers. The 		<p>order for a metal enclosure between the top of the fence and ceiling of the infectious waste storage has been completed and a copy has been given to Director of Quality. How are you going to prevent the deficiency from recurring in the future? Citation log from Steritech will be reviewed monthly for quality assurance. Information on the Steritech citation log will be shared with the Quality and Patient Safety Committee. Monitoring includes the actual performance, goal of 100%, and consequence of steps if not met. Who is going to be responsible for numbers 1 and 2? Director of Plant Management By what date are you going to have the deficiency corrected? Treatment has been performed and enclosure is in place. This rule is not met as evidenced by: In the cardio/ respiratory department equipment store room, six clean pulse oximeters were observed on the storage shelf contained in black refuse bags. The garbage bags were made from polyethylene polymers. The polymers come from ethylene gas, which derive from ethane gas. Plan of Correction ID Prefix Tag: S 1118 How are you going to correct the deficiency? Black bags made from polyethylene polymers will no longer be used for covering clean equipment. Black garbage bags, made from</p>		

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	<p>polymers come from ethylene gas, which derive from ethane gas. Six clean pulse oximeters were observed on the storage shelf contained in black refuse bags in the Cardio Respiratory Department equipment store room. The bags had an oil feel to them and the bags were in direct contact with the clean surfaces of the equipment.</p> <p>3. At 2:20 PM on 8/13/2013, staff member #6 indicated the department used to use clean patient plastic bags to cover their equipment. The Bulk Purchasing Department told the staff member to start utilizing the black garbage bags. The staff member indicated he/she discovered after the black garbage bags were used that the case of the bags does not state the bags are safe to cover patient care equipment. The staff member indicated patients that have allergy to oil could have a reaction from the residue the bags would leave on the clean equipment.</p>		<p>polyethylene polymers, have been removed from use as equipment covers. How are you going to prevent the deficiency from recurring in the future? Clear plastic bags have been ordered for use in covering clean equipment. All personnel will be educated and instructed to only use clear garbage bag from equipment covers. If the problem recurs, all staff will be instructed to notify their Director, Controller, or Quality Director. Set clear expectations regarding the use of clear plastic garbage bags for covering clean equipment. Who is going to be responsible for numbers 1 and 2? Infection Control RN By what date are you going to have the deficiency corrected? Completion as of September 13, 2013</p>		

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S001164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</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>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and staff interview, the facility failed to assure preventive maintenance was conducted on Environmental Service's automatic scrubbers, Rehabilitation's wooden steps, and washer/dryers.</p> <p>Findings included:</p> <p>1. Scott Memorial Hospital Preventive Maintenance Program policy (Last approved January 2013) states, "The Preventive</p>	S001164	<p>How are you going to correct the deficiency?New policies have been written to include preventative maintenance on environmental service's automatic scrubbers, rehab wooden steps and washer / dryer.Maintenance staff have been educated regarding new policy on preventative maintenance for automatic scrubbers, rehab wooden steps, and washer / dryer.How are you going to prevent the deficiency from recurring in the future?Set clear expectations regarding preventative maintenance as per hospital policy.Set clear consequence of not carrying out preventative maintenance on hospital equipment.Monitor Site</p>	09/03/2013
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	<p>Maintenance Program of Scott Memorial Hospital is designed to insure the protection of the lives of our patients and to protect the investment the public has undertaken in the establishment of this hospital. It is the duty of the Maintenance Director to administer the inspection on a daily, weekly, semi-annul, and yearly basis."</p> <p>2. After the Review of facility documents on 8/13/2013, the hospital lack evidenced of preventive maintenance was on the automatic floor scrubbers, Rehabilitation wooden steps, and washer/dryers.</p> <p>3. At 2:30 PM on 8/13/2013, staff member #4 confirmed the automatic floor scrubbers, Rehabilitation wooden steps, and washer/dryers were not on a preventive maintenance schedule.</p>		<p>FM site for deficiencies in preventative maintenance on a monthly basis. Information from Site FM monitoring will be shared with the Quality and Patient Safety Committee. Monitoring includes the actual performance, goal of 100%, and consequence of steps if not met. Who is going to be responsible for numbers 1 and 2? Director of Plant Management By what date are you going to have the deficiency corrected? Completed as of September 3, 2013.</p>		

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S001172	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(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:</p> <p>(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:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, documentation review, and interview, the facility failed to ensure medical records were not stored on the floor in the Medical Records/Film storage room and failed to provide environmental services in the dialysis storage room to prevent cross contamination to staff and patients.</p>	S001172	How are you going to correct the deficiency?Medical Records have been placed on storage shelving.How are you going to prevent the deficiency from recurring in the future?Medical Records personnel have signed acknowledging the policy on medical records storage.Set clear expectations regarding storage of medical records as per hospital policy.Set clear consequence of not carrying out proper storage of medical records.Environmental safety rounds will be conducted through the Medical Records department to ensure that proper storage of medical records is	09/03/2013

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	<p>Findings included:</p> <ol style="list-style-type: none"> Secured Medical Record Storage policy (Last approved 1/1/13) states, "Boxes should be placed on shelves not on the floor to facilitate easy retrieval." At 2:30 PM on 8/13/2013, the Medical Record/Film Storage room was toured. There were 12 storage cases of assorted medical records stored directly on the floor and not on the file storage racks they were stored adjacent to. Loose files were observed laying over the storage boxes in a disorganized manner. During the tour of the dialysis storage room at 1:40 PM on 08/13/13, accompanied by staff 		<p>completed. Who is going to be responsible for numbers 1 and 2? Director of Plant Management and Director of Medical Records By what date are you going to have the deficiency corrected? Completed as of September 3, 2013. Plan of Correction ID Prefix Tag: S 1172 How are you going to correct the deficiency? The dialysis storage room has been thoroughly cleaned by housekeeping. The dialysis storage room has been placed on a routine schedule of cleaning. How are you going to prevent the deficiency from recurring in the future? Staff educated on new policy for cleaning of dialysis storage room. Environmental safety rounds will be conducted throughout the hospital. Dialysis storage room will be included on these rounds. Set clear expectations regarding routine cleaning of dialysis storage room. Set clear consequence of not following routine cleaning schedules. Who is going to be responsible for numbers 1 and 2? Director of Plant Management. By what date are you going to have the deficiency corrected? Completed as of September 3, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2013
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NAME OF PROVIDER OR SUPPLIER SCOTT MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1451 N GARDNER ST SCOTTSBURG, IN 47170
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	<p>member #A1 and contracted service staff member #A20, the following observations were made:</p> <p>A. One clean dialysis machine in the center of the room.</p> <p>B. A shelving unit containing sterile supplies, containers of bleach, and containers of water and other fluid along the back wall.</p> <p>C. Two white towels, stained with an orange substance, on the floor in the corner.</p> <p>D. Dirt and debris on the floor carpet.</p> <p>E. A large amount of a white, crystallized substance all over the floor and on the lower shelf, which contained supplies.</p> <p>4. At 1:45 PM on 08/13/13, the dialysis staff member #A20, acknowledged the unsanitary condition of the room and indicated he/she did not know if anyone cleaned it, but he/she did not. He/she indicated the dialysis machine was cleaned before it was</p>			

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	<p>put into the room and confirmed all of the other supplies were clean and would be used on patients. He/she indicated the white substance looked like a container of solution had burst.</p> <p>5. At 3:00 PM on 08/13/13, staff member #A1 checked with the director of building services, staff member #A4, who confirmed the dialysis storage room was not on any schedule to be cleaned by the facility staff.</p>				