

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151333	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2014
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NAME OF PROVIDER OR SUPPLIER PUTNAM COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1542 S BLOOMINGTON ST GREENCASTLE, IN 46135
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 004765</p> <p>Survey Date: 7-14/16-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 07/25/14</p>	S000000		
S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, the hospital</p>	S000554	<p>S 554.1 Infection Control Correction: 7/14/14: Sprinkler Head trim was installed. The room</p>	08/06/2014

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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S000952	<p>created 3 conditions which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors.</p> <p>Findings:</p> <p>1. On 7-14-14 at 1:15 pm, in the presence of employees #A1, chief operating officer, and #A3, maintenance, it was observed in the radiology interventional room, there was a sprinkler head in the ceiling which did not have a piece of trim surrounding it. This caused an area in the ceiling tile to expose the room to material falling from the area above the ceiling to fall down into the patient care area.</p> <p>2. On 7-14-14 at 1:20 pm, in the presence of employees #A1 and #A3, it was observed in the nuclear medicine room, there was dust on the gamma camera. The patient came into direct contact with this camera.</p> <p>3. On 7-14-14 at 1:35 pm, in the presence of employees #A1 and #A3, it was observed in the MRI dressing area, there was dust on the top of a patient locker.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE</p>		<p>was inspected and other voids in ceiling were corrected. All areas of Radiology were cleaned and dusted by Housekeeping on 7/14/14.</p> <p>Prevention: The rooms will be periodically inspected for Infection Control Hazards. A policy outlining the areas to be cleaned and a request for a weekly cleaning was created by the Radiology manager and provided as an in-service to the Housekeeping supervisor with a recommendation that this same in-service be provided to the Housekeeping staff by the Housekeeping Supervisor. Exhibit # S 554-a Exhibit # S 554-b Exhibit 3 S 554-c Responsibility: It will be the responsibility of both Paul Sanders, Radiology Manager and Beth Little, Housekeeping Manager to over see this. Date of Completion: 8/6/2014: Policy put into place and Housekeeping staff has attended an in-service on the Imaging Department Cleaning Process and Schedule. Exhibit # S 554-a</p>				

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	<p>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 transfusion record review, policy/procedure review and staff interview, the facility failed to have documentation available to indicate policy/procedure for transfusion administration had been followed for seven of seven transfusions reviewed.</p> <p>Findings include:</p> <p>1. On 7/15/14 at 1:15 p.m. a policy/procedure titled: "Procedure for Blood Transfusion 100-36 Rev. 3/14" was reviewed which stated: "PRECAUTIONS 4. Check TPR (Temperature, Pulse, Respirations) & BP(Blood Pressure) prior to administering, (blood) for baseline to be used for later comparison."</p> <p>2. During review of transfusion records from 12:30 p.m. to 1:15 p.m. on 7/15/14, there was no documentation on the transfusion records to indicate step 4. listed above had been performed. SP (staff person)#2 offered to check patient</p>	S000952	<p>S 952 Nursing Services Correction: 8/5/2014: The nursing policy/procedure, 100-36E, was changed to include the following language: #6 – "Take pre-infusion VS". Exhibit # S 952-a 8/15/2014: The Blood Transfusion Form, PCH #4500, will be sent for re-printing. The pre-infusion VS will be recorded in the patient's electronic medical record until the new form is in place. Prevention: 8/11/2014: Education to staff completed regarding policy/procedure change. Memo Exhibit # S 952-b 9/1/2014: Blood Transfusion Record Audit will include monitoring of pre-infusion vital signs. Responsibility: The Director of Nursing revised the nursing policy/procedure and the transfusion record form. The nursing department manager, Kammie Meek, RN, will be responsible for providing education to the nursing associates. The laboratory manager or designee will be responsible for the Blood Transfusion Record audit. This audit is reported to the Pharmacy and Therapeutics Committee quarterly. The August/September audit will be reported at the October 2014 P&T Committee meeting. Date of Completion: 8/11/2014: Nursing will be documenting pre-infusion vital signs in the patient's electronic medical record until new form arrives.</p>	08/11/2014

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S001164	<p>charts for the above step 4. information and found:</p> <ul style="list-style-type: none"> a. 1 TPR&BP was done 1 hour prior b. 1 TPR&BP was done 2 hours prior c. 1 TPR&BP may have been done but no time was available on the "out" patient form. <p>3. In interview on 7/15/14 at 2:30 p.m. SP#1 and SP#2 acknowledged documentation of prior TPR&BP information was lacking.</p> <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. Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 1 piece of equipment.</p> <p>Findings:</p>	S001164	<p>S 1164.1 Physical Plant Correction: July 17, 2014: TriMedx completed a PM on the sleep study machine. Exhibit# S 1164-a Prevention: August 6, 2014: TriMedx has began documenting PM's for the sleep study machines. Exhibit # S 1164-b Responsibility: It is the responsibility of TriMedx to do the PM's on the sleep study machine as well as Jeff Mace,</p>	07/18/2014

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S001166	<p>1. On 7-14-14 at 11:45 am, employee #A3, maintenance, was requested to provide documentation of PM on a sleep study machine.</p> <p>2. In interview, on 7-15-14 at 10:40 am, employee #A3 indicated there was no policy to conduct a PM on the piece of equipment and employee #A4 indicated there was no documentation of PM and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</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>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks. Based on document review and interview, the hospital failed to keep current leakage checks on 1 piece of equipment.</p>	S001166	<p>Maintenance Director to over see this to completion. Date of Completion: July 18, 2014: TriMedx sent documentation on the PM's on the sleep study machine. Exhibit # S 1164-b</p> <p>S 1166 Physical Plant Correction: July 17, 2014: TriMedx will begin documenting the actual leakage current in the PM work order notes for all beds. Exhibit # S</p>	08/11/2014

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S001168	<p>Findings:</p> <ol style="list-style-type: none"> Review of a preventive maintenance (PM) document for an adult bed indicated it did not document current leakage checks. In interview, on 7-15-14 at 10:00 am, employee #A4 confirmed the above and no further documentation was provided prior to exit. <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the hospital failed to follow the manufacturer's recommendation for daily testing of 1 of 1 defibrillator.</p> <p>Findings:</p>	S001168	<p>1166-a Prevention: August 6, 2014: TriMedx has completed the PM for the sleep study machine. TriMedx also documented the actual leakage current in the PM work order notes. Exhibit # S 1166-b Responsibility: It will be the responsibility of TriMedx to do the PM's on the sleep study machine as well as documenting the actual leakage current in the PM work order notes. Jeff Mace, Maintenance Director will over see this to completion. Date of Completion: August 11, 2014: TriMedx will be documenting the leakage and the PM's on the sleep study machine. Exhibit # S 1166-c</p> <p>S 1168.1 Physical Plant Correction: August 2014: The Defibrillator Testing and Inspection Policy was revised, updating that Maintenance will begin performing daily checks on ALL defibrillators. Exhibit # S 1168-c August 7, 2014: Maintenance Department had a staff meeting regarding the Defibrillator testing. Exhibit # S 1168-d Prevention: August 7, 2014: Maintenance to do daily checks to verify that each of the Defibrillators spare batteries are fully charged and functional. Exhibit # S 1168-a Responsibility:</p>	08/11/2014

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	<p>1. Review of the manufacturer's manual for a hospital defibrillator, indicated a recommended checklist to test and inspect the device on a daily basis. The LIFEPAK 12 defibrillator/monitor Series OPERATOR'S CHECKLIST indicated the following:</p> <p>2. Inspect Power Source for: Broken, loose, or worn battery pins Two fully charged batteries installed Fully charged spare batteries available</p> <p>2. Review of a hospital policy NO 51-G-03, entitled LIFE PAK 12 MONITOR AND DEFIBRILLATOR CHECK & DOCUMENTATION, and a hospital policy 805-11, entitled Defibrillator Testing and Inspections, both approved 1-20-14, indicated they did not include the above-stated inspections of the power source.</p> <p>3. In interview, on 7-16-14 at 10:35 am, employee #A3, maintenance, confirmed the facility's policies and inspections did not include the above-stated manufacturer's requirements. No further documentation was provided prior to exit.</p>		<p>August 11, 2014: It will be the responsibility of the Maintenance Department to complete daily checks to verify that each of the Defibrillators spare batteries are fully charged and functional. Exhibit # S 1168-b Completion: August 11, 2014: Maintenance will begin completing all components of the "Operator's Checklist" daily. Exhibit # S 1168-g</p>	

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S001186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy in 1 instance.</p> <p>Findings:</p> <p>1. Review of HOSPITAL REGULATION #40-5, entitled "CODE RED" FIRE PLAN,</p>	S001186	<p>S 1186 Physical Plant Correction: July 2014: Hospital Regulation # 40-5 "CODE RED" Fire Plan was updated regarding Fire Drills. Exhibit # S 1186-a Prevention: July 28, 2014: The Safety Council discussed the fire drills during their meeting and the importance of having more in-services for associates to better prepare them for disasters. Responsibility: Steve Walters, Materials Management Manager and Jeff Mace, Maintenance Director will be responsible to over see the fire drills as well as other disaster drills. Completion: July 28, 2014</p>	07/28/2014
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	<p>REVIEWED : May 2013, indicated [there will be] monthly fire drills.</p> <p>2. Review of fire drills conducted at the facility for calendar year 2013, indicated there was no fire drill conducted for the month of September.</p> <p>3. In interview, on 7-15-14 at 10:15 am, employee #A3, maintenance, confirmed the above and no further documentation was provided prior to exit.</p>				