

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 11/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005061</p> <p>Dates: 11-5-14 to 11-6-14</p> <p>Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>Ken Ziegler, MT MS Medical Surveyor III</p> <p>QA Review: JLee 12-30-14</p>	S000000	<p>Please note that our letter was dated December 31, 2014 received the results via email until January 1, 2015.</p>	
S000320	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(G)</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>			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151317		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/07/2014	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee.</p> <p>Based on document review and interview, the chief executive officer (CEO) failed to maintain a policy for and implementation of providing employee post offer physical examinations in 2 of 12 instances. (S3 and S10)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of 12 personnel files, S#1-12, lacked evidence of employees #S3 and #S10 ever having had a post offer physical. #S3 date of hire (DOH) was indicated as 1/13/14 and #S10 DOH 9/15/14. 2. In interview on 11/6/14 at 4:30pm, A1 indicated post offer physical exams were eliminated from policy and procedure P&P last year due to the Infection Control (IC) Committee interpretation of the State rule. 3. Review of the document titled Infection Control Committee Meeting dated July 2, 2013 indicated two (2) paragraphs were elected to be removed from the P&P "Employ Health Exam". It could not be determined what a post offer physical was. 	S000320	<p>Tag S 320</p> <ol style="list-style-type: none"> 1. Employee Healthpolicy last updated on 08/29/2013 that removed the post offer physical. The policy was revised on 01/14/2015 toinclude the post offer physical by all employees (except for temporaryemployees and re-hires within one year) will have an employee physicalperformed by a mid-level provider or physician. The policy will go to the Infection Control Committee for approval on01/20/2015, then Hospital Board on 01/20/2015, then final approval will be fromMedical Staff on 03/11/2015. EmployeeHealth Nurse will schedule the appointment for the employee and follow-up thatthe physical has been completed. 2. Post offerphysical will be reported to the Governing Board through the Infection Control Committee. 3. The ChiefNursing Officer will monitor compliance. 4. The correction was completed on 01/14/2015 	01/14/2015			

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 11/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000392	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(2)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(2) That the services performed under a contract are provided in a safe and effective manner and are included in the hospital's quality assessment and improvement program.</p> <p>Based on document review and interview, the hospital governing body (GB) failed to ensure that services performed under contract were included in the quality assessment and improvement program (QAPI).</p> <p>Findings:</p> <p>1. Review of the first three (3) quarters of 2014 and the last quarter of 2013 QAPI meeting minutes lacked evidence of inclusion of the following contracted services: Ambulance, Anesthesia, Biohazard Waste Hauler, Blood Bank, Cardio/Pulmonary Therapy, Laboratory, Laundry, Tele Psychiatry (adult, adolescent & emergency).</p> <p>2. In interview on 11/6/14 at 3:25pm A13, Director of Quality, confirmed the above contracted services were not included in the QAPI program.</p>	S000392	<p>Tag S 392</p> <p>1.The Director ofQuality has met with each manager on an individual basis to discuss thecontracted services not currently listed in the QA/PI meeting minutes. The change was made and announced in theQuality Committee Meeting on 11/14/2014 that all managers have been met withand goals established for 2015. ThePerformance Improvement Program Policy was last updated on 11/06/2014. On 01/14/2015 the addition of contracted services was made. The policy will go to the Quality Committee for approval on02/06/2015, then Hospital Board on 02/17/2015, then final approval will be fromMedical Staff on 03/11/2015. Wewill be reporting quarterly in the Quality Minutes starting 04/03/2014. This information will</p>	11/14/2014

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 11/07/2014
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 document review and interview, the quality assurance and performance improvement program (QAPI) failed to include participation of all contracted and in-house services of the hospital for 8 of 11 contracted and 6 of 33 directly provided services.</p> <p>Findings:</p>	S000406	<p>then be reported quarterly at the Board Meetings that follow. The first Board Meeting following the first quarter of information will be 04/21/2015.</p> <p>2. The contracted services will be reported to the Governing Board through the Quality Council.</p> <p>3. The Chief Nursing Officer will monitor quarterly compliance.</p> <p>4. The correction was completed on 11/14/2014.</p> <p>Tag S 406</p> <p>1. The Director of Quality met with each manager on an individual basis to discuss the contracted services not currently listed in the QA/PI meeting minutes. The change was made and announced in the Quality Committee Meeting on 11/14/2014 that all managers have</p>	11/14/2014	

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 11/07/2014	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000718	<p>1. Review of the first three (3) quarters of 2014 and the last quarter of 2013 QAPI meeting minutes lacked evidence of inclusion of the contracted services of: Ambulance, Anesthesia, Biohazard Waste Hauler, Blood Bank, Cardio/Pulmonary Therapy, Laboratory, Laundry, Tele Psychiatry (adult, adolescent & emergency) and the directly provided services of: Biomedical engineering, Maintenance, Mammography, Occupational therapy, Post operative recovery, and Speech therapy.</p> <p>2. In interview on 11/6/14 at 3:25pm A13, Director of Quality, confirmed the above services were not included in the QAPI program and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(3)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p>		<p>been met withand goals established for 2015. ThePerformance Improvement Program Policy was last updated on 11/06/2014. On 01/14/2015 the addition of contracted services was made, pending approval. The policy will go to the Quality Committee for approval on 02/06/2015, then Hospital Board on 02/17/2015, then finalapproval will be from Medical Staff on 03/11/2015. We will be reportingquarterly in the Quality Minutes starting 04/03/2014.</p> <p>2.The contracted services will be reported to the Quality Committee and closely monitored eachquarter.</p> <p>3.The mangers willbe collecting the data and submitting to the Director of Quality who willreport to the Quality Committee.</p> <p>4.The correctionwas completed on 11/14/2014.</p>				

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 11/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(3) The hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry shall be authenticated promptly in accordance with the hospital and medical staff policies.</p> <p>Based on document review and interview, the hospital failed to ensure security and authentication of all record entries in 15 of 16 medical staff (MS)/allied health (AH) credential files reviewed. (MD1, MD3, MD4, MD5, MD6, MD7, MD8, MD9, MD10, AH1, AH1, AH2, AH3, AH4, AH5 & AH6)</p> <p>Findings:</p> <p>1. Review of 10 physician (MD1 - MD10) and six (6) allied health (AH1 - AH6) credential files indicated the following: MD1, M3, MD4, MD5, MD6, MD7, MD8, MD9, MD10, AH1, AH2, AH3, AH4, AH5 & AH6 lacked documentation of a statement for the medical staff member to keep confidential their computer password for electronic medical records.</p> <p>2. In interview on 11/6/14 at 1:30pm A24, Executive Assistant - Credentialing, confirmed the above lacked documentation of password confidentiality.</p>	S000718	<p>Tag S 718</p> <p>1.A review of all physicians with access to the EHR is being conducted to ascertain whether or not they have signed the EHR Access Agreement. The physician will be contacted to sign the Agreement if it is not available. All physicians that do not have the EHR access agreement signed by February 13,2015 will have their Log-In disabled until the form is completed.</p> <p>2.In the future this will be a part of the credentialing process and file.</p> <p>3.The Medical Records Director will conduct the review from a physician list provided by credentialing.</p> <p>4.This will be completed by February 13, 2015.</p>	02/13/2015

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 11/07/2014	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>This RULE is not met as evidenced by: Based on document review and medical record review, the hospital failed to ensure informed consents for treatment were signed for 3 of 26 medical records reviewed. (patients #17, #20 and #21)</p> <p>Findings: 1. Review of policy/procedure, #532500, Consent to Treat, indicated the following; "POLICY: All persons who require treatment in Greene County General Hospital, must have a "Consent to Treat" form signed prior to receiving care. PROCEDURE: a. Patient registration staff will have the patient sign the "Consent to Treat" form at the time of check-in. b. In the event the patient is unable to sign, it is signed by a person who meets the legal qualifications to be able to sign." c. It will be the responsibility of nursing to</p>	S000754	<p>Tag S 754</p> <p>1.Any consent for treatment that is not obtainable due to patient condition at the time of admission and no representative available will be noted on the virtual chart communication area. Local nursing homes have been contacted to request that patient representatives contact the hospital when they notify the representative that a resident is being transported to the hospital. 2.These patients will be followed up as soon as possible by the nursing staff and communication made on the virtual chart will be removed once a representative has been contacted for consent or the patient is able to sign the consent.</p>	01/31/2015			

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 11/07/2014	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>obtain the signature for "Consent to Treat" if the registration staff cannot obtain the signature. This policy/procedure was last reviewed/revise on 8/30/2013.</p> <p>2. Review of policy/procedure Operating Room-General Policies indicated the following: #3. Permits for operations are signed for every procedure. The patient having the surgery is the person who should sign an informed consent. If the person is under 18 years of age, a parent or legal guardian may sign." This policy/procedure was last reviewed/revise on 3/2014.</p> <p>3. General or treatment consents could not be located in patient's #17, #20 and #21 Medical Records, signed by patients, another person who meets the legal qualifications to sign for the patient, or notation, by staff, for emergency treatment needed at once.</p> <p>Review of the following medical records (MR) indicated the following: Patient #17 was admitted to the hospital on 7/2/2014 and the MR lacked documentation of an informed consent for treatment. Patient #20 was admitted to the hospital on 7/11/2014 and the MR lacked documentation of an informed consent for treatment. Patient #21 was admitted to the hospital on 7/20/2014 and the MR lacked documentation of an informed consent for treatment.</p> <p>4. Consent to treat forms for patients #17, #20 and #21 were requested from staff member #2, the Chief Nursing Officer, and none was provided prior to exit.</p>		<p>3.The Medical Records Director will conduct the review from a physician list provided by credentialing. 4.This will be implemented on January 31, 2015</p>				

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 11/07/2014	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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).</p> <p>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 of ten patients.</p> <p>Finding(s) include:</p> <p>1. On 11/05/14 at 12:50 p.m. the policy, "Blood Transfusions", PolicyStat ID 763966, revised 2/28/2014, read: "Send request for transfusion to laboratory via = Blood Bank = in computer. As ordered by physician."</p>	S000952	<p>Tag S 952</p> <p>1.Fields have been edited within the Order Entry Question section of the computerized orders. The edit made requires a specific number of units of blood products be chosen. We currently have a drop down option with 0-8 units available. This is a required-answer field that cannot be avoided; orders cannot be completed w/o documentation in this field. The change was made 11/06/2014</p> <p>2.The edits mentioned will force the physician or staff member ordering the Blood Bank services to appropriately complete the order with the number of units desired. If a staff member is placing the order from a hand-written order, this change to format will trigger staff to ensure the number of units is addressed. They will not be able to proceed with order placement until the order has been clarified.</p> <p>3.The Lab Manager will be</p>	11/07/2014			

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 11/07/2014	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S001114	<p>2. On 11/05/14 at 1:00 p.m. review of one patient receiving two blood units indicated each of these received-units had been administered without complete documentation, per policy, on the Blood Transfusion Record form including:</p> <p>Patient #8 --Both unit #11 administered on 9/13/14 at 1900 and unit #12 administered on 9/13/14 at 2255 had been administered without benefit of a Physician's order stating two units were to be administered.</p> <p>3. On 11/05/14 at 12:45 p.m., staff member #12 acknowledged that the above-listed patient had received these two blood units without benefit of a Physician's order stating two units were to be administered.</p> <p>410 IAC 15-1.5-8</p>		<p>responsible for the auditing of data to maintain compliance</p> <p>4. The correction was completed on 11/06/2014</p>				

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 11/07/2014
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(1)</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>(1) No condition in the facility or on the grounds shall be maintained which may be conducive to the harborage or breeding of insects, rodents, or other vermin.</p> <p>Based on observation, the hospital created conditions conducive to the harborage or breeding of insects, rodents, or other vermin in three (3) areas.</p> <p>Findings:</p> <p>1. During tour of the hospital on 11/5/14 between 9:45am and 11:45am, in the presence of A1, Chief Executive Officer, and A10, Plant Operations Manager, the following was observed in the boiler room: multiple cardboard boxes on the floor, four (4) of which appeared to have been wet and damaged; in the medical air compressor room: cardboard boxes directly on the floor with heavy dust noted behind, and a concrete block wall broken with exposed holes; and in a canopied area near the receiving dock, two (2) nest like structures under the canopy.</p>	S001114	<p>Tag S 1114</p> <p>1.a. Cardboard boxes were removed from the boiler room and medical air compressor room on 11/06/2014. b. There was a work order submitted on 11/17/2014 to fix the concrete block wall in the Medical Compression Room. The concrete block wall was repaired on 11/24/2014.</p> <p>2.c. There was a work order submitted on 11/13/2014 to remove the nests under the canopy. They were removed on 11/06/2014.</p> <p>3. A quarterly hospital safety survey will be conducted starting 03/04/2014 to maintain compliance</p> <p>4. Plant Operations Manager will be monitor the storage of boxes and other areas that could harbor insects, rodents, or other vermin.</p> <p>5. The correction was completed on 11/24/2014</p>	11/24/2014	

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 11/07/2014	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S001118	<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 document review and observation, the hospital created conditions that may result in a hazard to patients, public, or employees in four (4) instances.</p> <p>Findings:</p> <p>1. Review of the policy titled Compressed Gas Cylinders: Storage, Use, and Handling, effective date 10/23/14, indicated in #2. All cylinders must be stored in a rack, a cart, or other enclosure to prevent falling or tipping.</p> <p>2. Review of the material safety data sheet (MSDS) for the Conductivity Neutralizing Solution indicated under #4. Fire/Explosion hazards...vapors flammable...May be ignited by heat, sparks, or flames. Conditions to avoid: Extreme heat, temperatures. Protect from</p>	S001118	<p>1. A work order was submitted to chain up the cylinders on 11/19/2014 in the medical gas storage area. It was completed on 11/20/2014.</p> <p>1.A work order was submitted on 11/18/2014 to remove all cardboard from electrical panels. The HVAC room was searched and cardboard boxes removed from atop electrical boxes on 11/20/2014. The spray paint cans were removed atop electrical boxes 11/07/2014.</p> <p>2.A work order was submitted on 11/18/2014 to secure the cylinders in the maintenance department. It was completed 11/20/2014 in the maintenance department including the Medical Air Compressor Room.</p> <p>3. On 11/07/2014 there was a work order entered for to disconnect electrical to cabinet in the Boiler Room. It was</p>	11/20/2014			

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 11/07/2014	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S001150	<p>sparks, flames, oxidizers.</p> <p>3. During tour of the hospital on 11/5/14 between 9:45am and 11:45am in the presence of A1, Chief Executive Officer and A 10, Plant Operations Manager, the following was observed:</p> <p>a. In the medical gas storage area unsecured were two (2) small and two (2) large Nitrous Oxide tanks.</p> <p>b. In the HVAC room, two (2) spray paint cans and two (2) small cardboard boxes atop an electrical box, two (2) binders atop another electrical box and cardboard boxes atop two other electrical boxes.</p> <p>c. In the medical air compressor room, an unsecured tank labeled R22 compressed gas with a warning label - DO NOT DROP and three (3) other unsecured yellow cylinder/tanks sitting on the floor in a pile and one (1) unsecured fire extinguisher.</p> <p>d. In the boiler room, inside a chemical test storage cabinet, a bottle indicated to be Conductivity Neutralizing Solution was being stored next to exposed electrical wires with only wire nuts covering the ends. The solution bottle label indicated "Danger - Flammable".</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p>		<p>completed on 11/11/2014. The solution bottle was removed on 11/06/2014.</p> <p>2. A quarterly hospital safety survey will be conducted starting 03/04/2014 to maintain compliance. 3. Plant Operations Manager will be monitor the storage of boxes and other areas that could harbor insects, rodents, or other vermin. 4. The correction was completed on 11/20/2014</p>				

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 11/07/2014
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S001164	<p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation and interview, the facility failed to install back flow prevention devices in one steam room.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During tour of the hospital on 11/5/14 between 9:45am and 11:45am, in the presence of A1, Chief Executive Officer, and A10, Plant Operations Manager, the following was observed in the steam room; three (3) water spigots with rubber hoses attached and no evidence of a back flow prevention device on any of the three. 2. In interview on 10/5/14 at 10:30am, A10 confirmed the spigots did not have a visible or non-visible back flow prevention device. <p>410 IAC 15-1.5-8</p>	S001150	<p>Tag S 1150</p> <ol style="list-style-type: none"> 1.A work order was submitted to install backflow preventers on all hoses on 11/13/2014 in the SteamRoom. It was completed on 11/17/2014. 2.A quarterly hospital safety survey will be conducted starting 03/04/2014 to maintain compliance 3.Plant Operations Manager will be responsible for the monitoring of continued compliance. 4. The correction was completed on 11/17/2014 	11/17/2014	

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 11/07/2014
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>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 observation, document review and interview, the hospital failed to provide evidence of preventive maintenance for all equipment in six (6) instances.</p> <p>Findings:</p> <p>1. During tour of the facility on 11/5/14 at 11:00am in the presence of A1 and A10, the following was observed: in the rehabilitative therapies area a Sports Art Bike (recumbent exercise bike), wooden therapy stairs, parallel bars, and a wall mounted pulley without evidence of current preventive maintenance (PM). Evidence of PM was requested of A10 at that time.</p> <p>2. Review of preventive maintenance (PM) documentation for both the contracted service and the in-house PM service lacked documentation for PM of</p>	S001164	<p>Tag S 1164</p> <p>1.Theaddition of exercise bike, patient stair climber, parallel bars, overheadpulley were added to the list of preventive maintenance on 11/07/2014 formaintenance. 1.The Fluid (blood)Warmer had last PM on 12/17/2014, per Clintech Corporation. 1.A quarterlyhospital safety survey will be conducted starting 03/04/2014 to maintaincompliance 2.Plant OperationsManager will be monitor the storage of boxes and other areas that could harborinsects, rodents, or other vermin. 3. The correction was completed on 11/07/2014</p>	11/07/2014	

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 11/07/2014
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY GENERAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1185 N 1000 W LINTON, IN 47441		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the following items: exercise bike, patient stair climber, parallel bars, physical therapy overhead pulley, and blood warmer.</p> <p>3. In interview on 11/6/14 at 4:15pm A10, Plant Operations Manager, confirmed the facility did not have documentation of PM for the above items and no further documentation was provided prior to exit.</p>				