

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2013
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NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
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S000000	<p>This visit was for one (1) State complaint investigation.</p> <p>Dates of survey: 05/16/13</p> <p>Facility number: 004975</p> <p>Complaint number: IN00126463 Unsubstantiated; lack of sufficient evidence. Deficiencies unrelated to allegations are cited</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 05/28/13</p>	S000000		
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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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S000308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and staff interview, the facility failed to ensure 3 agency staff (#1, 2, and 3) and 1 facility employee (#5) received hospital and department orientation.</p> <p>Findings include:</p> <p>1. Facility policy titled "General and Departmental Orientation" last reviewed/revised 6/08 states: "B. All employees (FT/PT/PRN/Temporary) are required to attend a general orientation session prior to their first day of work or, in no event, no later than within the first 30 days of their employment. New Employee Orientation is scheduled at least monthly. Department of Health and OSHA regulations require certain types of training prior to the start of work on the</p>	S000308	<p>Who is responsible:</p> <p>Krista Hall, RN, Doug Lee, Director of Human Resources, and Virginia Ottersbach, RN, CNO</p> <p>What is the plan of correction:</p> <p>A general facility orientation has been established and scheduled to occur monthly for new employees and agency staff.</p> <p>When the plan of correction will begin:</p> <p>06/25/2013</p> <p>How the plan of correction will occur:</p> <p>Within 30 days of hire, new employees and agency</p>	06/25/2013			

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	<p>floor and those items will be included as part of the department specific orientation to assure proper training.....D. Volunteers, Allied Health professionals, and Contract/Agency personnel must attend New Employee Orientation or complete a self-study orientation packet prior to beginning their assignment at the facility. Documentation of such orientation must be maintained. E. In addition to the general facility orientation, each Department Manger is required to assure that new employees are properly oriented to the Department in which he/she works. Consistent with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, and state Department of Health standards all Departmental Orientation should start within the first 5 days of hire and continue until completed but no later than within the first 30 days of employment....."</p> <p>2. Review of daily staffing sheets for 3/13/13- 3/15/13 indicated the following: (A) Agency staff #1 worked on the medical/surgical (med/surg) unit on 3/13/13. (B) Staff member #5 (date of hire 10/12) worked on the med/surg unit on 3/14/13. (C) Agency staff #2 and #3 worked on the med/surg unit on 3/15/13.</p>		<p>employees will attend a facility orientation with a timed agenda that includes training sessions presented by department directors. Each department director will orient new employees to the area of the hospital specific to their department. The topics trained in this 8 hour orientation day will include:</p> <ul style="list-style-type: none"> ·Patient rights, patient abuse and staff relations ·Infection prevention, Risk Management, and Quality Improvement ·Glucometer and Lab Training ·Administrative welcome, Mission, Values, EMTALA, and HIPPA ·Environment of Care, Fire and electrical safety, Bioterrorism, and Plant Operations ·Staff benefits ·Computer system and electronic medical record training ·Orientation to hospital annual training requirements such as CPR, Telemetry, Behavioral Health, and annual skills days <p>Documentation will be maintained that all new employees, permanent and agency, receive this facility orientation.</p>				

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	<p>3. Personnel files for agency staff #1 (LPN), #2 (RN) and #3 (LPN) as well as staff member #5 (RN) lacked documentation of orientation.</p> <p>4. Staff member #1 verified in interview at 3:45 p.m. on 5/16/13 that personnel files for agency staff #1, 2, and 3 as well as staff member #5 lacked documentation of orientation as required per policy.</p>				

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S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and staff interview, the facility failed to update/review policies at least triennially for 3 of 3 policies.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "General and Departmental Orientation" was last reviewed/revised 6/08. 2. Facility policy titled "ISOLATION PRECAUTIONS" was last reviewed/revised 4/09. 3. Facility policy titled "ADMITTING PROCEDURES" was last reviewed/revised 12/09. 4. Staff member #2 verified in interview at 2:40 p.m. on 5/16/13 that facility 	S000322	<p>Who is responsible:</p> <p>Virginia Ottersbach, RN, CNO with the approval of the Quality Council and Medical Executive Committee</p> <p>What is the plan of correction:</p> <p>All facility policies will be reviewed and/or updated every three years.</p> <p>When the plan of correction will begin:</p> <p>06/13/2013</p> <p>How the plan of correction will occur:</p> <p>Virginia Ottersbach, RN, CNO will review all facility policies and document this review by dating each policy with the date it was reviewed. Any policies found</p>	06/13/2013	

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	policies had not been updated triennially.		needing updates will be taken before the Quality Council for approval and then forwarded to the Medical Executive Committee for final approval and signature of Medical Director.	

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S000946	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(4)</p> <p>(c) Drugs and biologicals shall be prepared for administration and administered as follows:</p> <p>(4) In accordance with the signed written orders of the practitioner or practitioners responsible for the patient's care. When verbal or telephone orders are used they shall be accepted only by personnel that are authorized to do so by the medical staff rules.</p> <p>Based on document review and staff interview, the facility failed to ensure nursing staff administered medications according to physician order for 1 of 5 patients.</p> <p>Findings include:</p> <p>1. Review of patient #1 medical record indicated the following: (A) An order was written on 3/14/13 for Levaquin 750 mg every 24 hours as part of the patients admission orders. The patient was admitted at 8:35 p.m. on 3/14/13 and the orders were "noted" by the RN at 10:00 p.m. Per review of the medication administration record (MAR) for 3/14/13 and 3/15/13, the Levaquin was not administered on 3/14/13 and was not initiated until 9:00 p.m. on 3/15/13. (B) An order was written on 3/16/13 for</p>	S000946	<p>Who is responsible: Virginia Ottersbach, RN, CNO What is the plan of correction: A newly developed policy titled "Medication Administration"</p> <p>When the plan of correction will begin: The policy was written on 7/11/2013 and will be taken to Quality Council for approval on 7/23/2013. The policy will then be forwarded to the Medical Executive Committee on 8/14/2013 for final approval and signature of hospital Medical Director. How the plan of correction will occur: A facility policy was written to address the procedure for medication administration. The purpose of this policy is to ensure that medications are placed on a house wide medication schedule, and that medications are given according to this set schedule and frequency ordered. This policy also addresses newly</p>	08/14/2013	

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	<p>Vancomycin 1.5 gm I.V. tonight and then per pharmacy recommendation. Pharmacy recommendation on 3/17/13 was to continue the 1.5 gm of Vancomycin every day at 11:00 p.m. Review of the MAR for 3/14/13 through 3/20/13 indicated the patient did not receive the Vancomycin on 3/19/13.</p> <p>2. Staff member #1 verified in interview at 2:15 p.m. on 5/16/13 that the antibiotics were not administered per physician order for patient #1 and the Levaquin should have been started on the evening of admission.</p>		<p>ordered antibiotics and sets a time frame policy for first dose administered. Nightly chart audits by the house supervisor in collaboration with medication reconciliations by the facility pharmacy staff using our newly installed electronic medical record system will ensure compliance of this policy.</p>		