

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2014
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NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 3/3/2014 through 3/5/2014</p> <p>Facility Number: 005019</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 03/18/14</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, manufacturer's directions, policy and procedure review, and interview, the facility failed to ensure a safe environment for patients</p>	S000554	<p>Outside shipping boxes: How are you going to correct the deficiency? Nurse Managers will make certain that all items will</p>	03/31/2014

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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	<p>by checking supplies to prevent outdated usage, dating products to prevent outdated usage, and ensuring clean supplies and equipment were protected from contamination in patient care areas.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the Med/Surg Unit at 1:30 PM on 03/03/14, accompanied by staff member A8, the following observations were made: <ol style="list-style-type: none"> Outside shipping boxes stored alongside clean, unpackaged supplies in the medication room, the clean supply room, and the store room/pantry. One of one infant lumbar puncture kit, with an expiration date of 02/2014, on a storage rack. Two bottles of control solution and one container of strips (glucometer supplies) were open, but not dated, on the unit. At 2:10 PM on 03/03/14, staff member A12 on the unit indicated he/she did not know about dating the glucometer supplies or about any expiration date other than the manufacturer's date. During the tour of the Intensive Care Unit at 2:20 PM on 03/03/14, accompanied by staff member A8, the 		<p>be removed from outside shipping boxes and items placed in drawers or clean storage containers in Med/Surg, ICU and ER. How are you going to prevent the deficiency from recurring in the future? A policy was developed to address the issue of not storing outside shipping boxes in patient care areas. The policy was shared with the staff, and the Nurse Managers will monitor these areas on a weekly basis for three months, then monthly for nine months, and then periodically to assure compliance. The monitoring data will be reported to the Performance Improvement Committee (PIC) quarterly. The policy was posted in areas utilized for staff communication, and shared with the staff at the unit department meetings on March 6th and March 27th. <u>Outdated items: Infant lumbar puncture kit expired: How are you going to correct the deficiency?</u> Kit was removed and discarded. Staff educated on the process for monitoring expired items. Person in charge of monitoring the cart received counseling regarding the expired item. How are you going to prevent the deficiency from recurring in the future? Area assigned to nursing personnel to check for outdates on a monthly basis. Nurse Manager will monitor this area for outdates on a monthly basis for three months,</p>				

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	<p>following observations were made:</p> <p>A. Outside shipping boxes stored alongside clean, unpackaged supplies in the storage/pantry area.</p> <p>B. Two bottles of control solution and one container of strips (glucometer supplies) were open, but not dated, on the unit.</p> <p>4. At 2:30 PM on 03/03/14, staff member A18 on the unit indicated he/she thought the glucometer supplies were good until the manufacturer's expiration date.</p> <p>5. During the tour of the Emergency Department at 2:40 PM on 03/03/14, accompanied by staff member A8, the following observations were made:</p> <p>A. Outside shipping boxes stored on shelves alongside clean, unpackaged supplies in the large supply room.</p> <p>B. Two bottles of control solution and one container of strips (glucometer supplies) were open, but not dated, on the unit.</p> <p>C. Two of two containers of iodoform packing with an expiration date of 02/2014 in the Eye/Ear cart in the hallway.</p> <p>6. At At 2:45 PM on 03/03/14, staff members A15 and A16 indicated they did know about dating the glucometer</p>		<p>then monthly for nine months and then periodically to assure compliance. The monitoring data will be reported to the PIC quarterly. <u>Expired iodoform packing in the Eye/Ear cart in the hallway - How are you going to correct the deficiency?</u> Expired iodoform packing was discarded on March 3, 2014. <u>How are you going to prevent the deficiency from recurring in the future?</u> All areas are assigned to nursing personnel to check for outdates on a monthly basis. The Nurse Manager will monitor this area on a weekly basis for three months, then monthly times nine months, and then periodically to assure compliance. The monitoring data will be reported to the PIC quarterly. <u>Glucometer strip and solutions open and not dated, staff unaware of expiration rules: How are you going to correct the deficiency?</u> All open and not dated glucometer strips and control solution were discarded and replaced on March 3, 2014. Reinforced education on policy for dating strips and control solution when open and rules for discarding on March 6th and March 27th at unit meetings. <u>How are you going to prevent the deficiency from recurring in the future?</u> All units Med/Surg, ICU, ER and the Surgery Department (including the Extension building)</p>		

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	<p>supplies.</p> <p>7. During the tour of the Surgical Unit at 3:40 PM on 03/03/14, accompanied by staff member A17, six of six packages of sterile tongue depressors, with an expiration date of 02/2014, were observed on the anesthesia cart in room 118.</p> <p>8. During the tour of the Endoscopy Unit at 4:00 PM on 03/03/14, accompanied by staff member A17, an open container of Cidex OPA, dated 10/10/13, was observed on the shelf. Label directions indicated the chemical should be discarded 75 days after opening.</p> <p>9. During the tour of the Surgery Extension at 1:30 PM on 03/04/14, accompanied by staff member A17, the following observations were made: A. Two open bottles of control solution, dated 04/04/14, and one open, but not dated, container of strips (glucometer supplies) on the unit. B. A container of HemoPoint Microcuvette, dated as opened 08/06/13. Label directions indicated to use within 90 days after opening.</p> <p>10. At 1:40 PM on 03/04/14, staff member A17 called staff member A32</p>		<p>have been educated at unit meetings on March 6th and March 27th on the current policy and procedure for dating open glucometer strips and QC. Education included information that control solutions are to be discarded within 180 days of being opened and strips discarded after 90 days, as per manufacturer's recommendations. Nurse Managers and Director of Surgical Services will monitor on a weekly basis for 3 months, then monthly for nine months, and then periodically to assure compliance. Data will be reported to PIC. Education included containers to be clearly marked with opening dates. tongue depressors on Anesthesia Cart in Room 118 How are you going to correct the deficiency? Tongue depressors disposed on March 3, 2014, staff educated to check for outdates on a monthly basis and to report their results to the Director as part of the process for monitoring outdates. How are you going to prevent the deficiency from recurring in the future? Staff educated on March 3rd with one-on-one education. Area assigned to nursing personnel to check for outdates on a monthly basis. QA study currently being done on checking outdates. Will continue QA and continue reporting to PIC. <u>Container of HemoPoint Microcuvette</u></p>				

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	<p>who indicated he/she thought the glucometer control solutions were dated for 2 months after opening.</p> <p>11. The facility policy "Bedside Glucose Monitoring- Nova Stat Strip Glucose Hospital Meter, Nursing", last revised 03/31/2011, indicated, "When opening a new bottle of control, write the current date on the bottle label. Each bottle of control solution is stable for 90 days after opening. Discard all unused solutions 90 days after opening. When opening a new bottle of strips, write the current date on the bottle label. Each bottle of strips is stable for 180 days after opening. Discard all unused strips 180 days after opening."</p>		<p><u>expires 90 days after opening. opened 8-6-13. How are you going to correct the deficiency?</u> Expired HemoPoint Microvettes were disposed of on March 4, 2014. Surgery staff educated one-on-one March 4th on the process for monitoring for outdates. How are you going to prevent the deficiency from recurring in the future? Director of Surgical Services will monitor on a weekly basis x3 months, then monthly for nine month, and then periodically to assure compliance. Data to be reported to PIC. Open bottle of Cidex dated 10/10/13 expires 75 days after opening How are you going to correct the deficiency? Expired Cidex was discarded on March 3, 2014. How are you going to prevent the deficiency from recurring in the future? Surgery and Radiology staff educated one-on-one on March 3rd on how to find and follow manufacturer's recommendations regarding when to dispose of a product after opening. Container to be clearly marked with opening date. Who is going to be responsible for this Tag: Director of Infection Prevention</p>	

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S000556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the hospital failed to record the time of the PPD skin test readings for 33 of 33 hospital employees in assuring the PPD tests were placed and read within 48-72 hours per CDC guidelines and hospital policy (A1, A2, A3, A4, B1, B2, B3, B4, B5, B6, C1, C2, C3, C4, C5, C6, C7, D1, D2, D3, E1, E2, E3, E4, #s 1 through 8 and 10).</p> <p>Findings included:</p> <p>1. CDC guidelines specify the Purified Protein Derivative (PPD) timed skin test responses should be measured 48-72 hours after</p>	S000556	<p>Failure to document time of reading PPDs How are you going to correct the deficiency? As of March 26, 2014 Business Health began documenting TB Skin Test "Read" time in the "Comment" section of current Systoc form. A new policy was drafted by Business Health on TB Skin Tests that clearly documents how tests are to be placed & read, including that they will ONLY be read between 48 & 72 hours with "read" time documented in the comment section. How are you going to prevent the deficiency from recurring in the future? Education was completed for the Business Health staff on March 26th regarding the new policy and how to monitor for compliance. Read time documentation began March 26, 2014. New policy went into effect on April 1st. A report will be run weekly for a period of two months, then if this proves to be effective the report will be done on a monthly basis for the</p>	03/26/2014			

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	<p>administration.</p> <p>2. On 3/03/14 at 3:30 p.m., the PPD skin tests were reviewed with staff member #10 who acknowledged negative PPD readings observed in the staff members' health care records. These records included employee #'s 1 through 8 and 10 with their respective hire dates on 6/26/00, 10/08/13, 9/04/12, 8/06/01, 9/04/13, 6/20/94, 7/31/98, 3/04/13, and 9/13/04. Each record contained no documentation to indicate their TB test results had been read within 48-72 hours.</p> <p>3. In interview on 3/03/14 at 4:30 p.m., staff member #10 acknowledged that each of these nine employee files failed to contain timed documentation indicating when each PPD test result had been read within 72 hours.</p> <p>4. Gibson General Hospital Tuberculosis Program (Last approved 7/19/2013 states, "The</p>		<p>remainder of the year. A manual back-up plan has been put into place to insure the reading time is recorded. This data will be reported to PIC quarterly. Who is going to be responsible for this Tag: Director of Infection Prevention</p>				

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	<p>TST result should be read by a designated, trained HCW 48-72 hours after the TST is placed. If the TST was not read between 48-72 hours, ideally, another TST should be placed as soon as possible and read within 48-72 hours."</p> <p>5. Health Care records were reviewed for 24 hospital employees: A1, A2, A3, A4, B1, B2, B3, B4, B5, B6, C1, C2, C3, C4, C5, C6, C7, D1, D2, D3, E1, E2, E3, and E4. The hospital failed to record the time of the PPD skin test readings after they were placed for 24 of 24 hospital employee records that were reviewed. The facility could not provide documented evidence that the PPD skin test test responses were measured 46-72 hours after administration</p>				

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S000596	<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> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure chemical Cidex OPA was used according to the manufacturer's recommendations in the Imaging Department.</p> <p>Findings included:</p> <p>1. The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for semi-critical devices. Cidex OPA manufacture sheet requires: Manual rinsing</p>	S000596	<p>Cidex rinsing not based on manufacturer's recommendations How are you going to correct the deficiency? The ultrasound tech started rinsing the probe with 2 gallons of water 3 times for 1 minute each per Cidex manufacture recommendations. This started on March 4, 2014. The policy and procedure for use of Cidex will be updated by March 28, 2014 to reflect the above. Staff will be trained on the proper rinsing procedure for Cidex. Director of Radiology will monitor the rinsing process 2 times a month for 3 months (April, May, June, 2014) and report the findings to PIC. How are you going to prevent the deficiency from recurring in the future? Radiology is updating their policy</p>	03/28/2014			

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	<p>procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done.</p> <p>2. At 2:15 PM on 3/4/2014, staff member #11 explained the rinsing off of the vaginal probes in the Imaging Department's Ultrasound Room. The staff member indicated the department used to rinse the probes off in 3 separate containers of 2-gallons water each. However, the facility purchased a GUS ventilation system which the unit has a 32-ounce container for water. The staff would submerge the vaginal probe in the 32-ounce container of water for 60 seconds followed up by rinsing the probe off with running water for an additional 60 seconds.</p> <p>3. The staff member confirmed the GUS system of rinsing off</p>		<p>on manual high-level disinfection with a change to Rapicide. Cidex will not be used after the depletion of the current inventory of Cidex (4 gallons). The policy will include manual rinsing of Rapicide per manufacturer recommendations: Following removal from RAPICIDE OPA/28, thoroughly rinse the semi-critical device by immersing it in a large volume of water (e.g. 8 liters). Use rinse water that is consistent with the directions provided below (see section 3). Keep the device entirely submersed for a minimum of 1 minute in duration, unless a longer time is specified by the reusable device manufacturer. Remove the device from the water and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing for any other purpose. Repeat the procedure for rinsing manual devices TWO additional times for a total of THREE RINSES with large volumes of fresh water to remove Rapicide OPA/28 HLD residues. Proper rinsing of devices is required, see warnings and precautions. Three separate large volume water immersion rinses are required unless otherwise specified by device manufacturer's instructions. Who is going to be responsible for this Tag: Director of Infection Prevention</p>		

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S000598	<p>semi-critical devices does not meet the requirement of Cidex OPA.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on observation and staff interview, the facility failed to ensure the Imaging Department was complying with FDA requirements on not refilling Ultrasound Gel containers.</p> <p>Findings included:</p> <p>1. FDA indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill,</p>	S000598	<p><u>Refilling ultrasound gel bottles</u> How are you going to correct the deficiency? The policy and procedure was updated/changed to reflect that ultrasound gel bottles will no longer be refilled or "topped off". Staff were educated on the new policy and procedure at each respective department's next monthly staff/departmental meeting. The Rehab and Radiology staff was notified of the new policy and procedure and process at their staff/departmental meeting on 3/18/14. New staff are required to review, read, sign and date the</p>	03/18/2014
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	<p>the growth of bacteria. However, past studies have demonstrated that ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA recommends that Ultrasound Gel containers not to be refilled.</p> <p>2. At 2:00 PM on 3/4/2014, the Radiology Department Ultrasound room was inspected. Located in the room was a counter with several 16-ounce ultrasound gel containers inside the counter with a partial bulk plastic container of Aquasonic Ultrasound Gel. On the counter top was a Aquasonic Gel thermal sonic warming unit with plastic bottles warming in the unit.</p> <p>3. At 2:15 PM on 3/4/2014, staff member #10 indicated he/she refills the ultrasound gel plastic bottles. The staff member</p>		<p>departmental policy and procedure manual during their orientation. How are you going to prevent the deficiency from recurring in the future? Department directors and managers in departments that utilize ultrasound gel will check expiration dates on the bottles weekly to make sure compliance is maintained. The results of this tracking will be reported quarterly in PIC by department directors/managers. Annually, staff are required to review, read, and sign the departmental policy and procedure manual. This will ensure continued education and compliance in the process. Who is going to be responsible for this Tag: Director of Infection Prevention</p>		

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S000754	<p>indicated a box containing 1 empty plastic bottle and a 5L bulk plastic container of Aquasonic Ultrasound Gel. The empty plastic container would be refilled several times with the bulk container of ultrasound gel until it is empty.</p> <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>Based on the review of the Blood/Blood Products Administration policy and staff interview, the hospital failed to complete all documentation for evidence of informed consent using procedures and</p>	S000754	<p>All inpatient records shall contain evidence of appropriate informed consent for procedures/treatments</p> <p>How are you going to correct the deficiency? At the March 6th and March 27th department meetings the Managers reinforced staff education regarding appropriate completion</p>	03/31/2014

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	<p>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 for two of ten patients receiving blood.</p> <p>Findings included:</p> <p>1. On 3/03/14 at 1:00 p.m., review of the policy, "Blood Transfusion", revised 08/10/14, read: "Obtain signed consent from patient for the administration of blood or blood products."</p> <p>2. On 3/03/14 at 1:30 p.m., two patients (#s 6 and 10) each received two blood units without documentation of complete consent forms including:</p> <p>Patient # 6 --Both units including unit # 1) given on 2/04/14 at 1115 and unit #2) given on 2/04/14 at 1530</p>		<p>of Consent to Blood Product Transfusion form completion, verification of Consent for Blood Administration and review of chart processing. The Blood Transfusion Policies were revised to include witness the consent, "obtain a signed consent from the patient and witness the consent for administration of blood or blood products". How are you going to prevent the deficiency from recurring in the future? At the March 6th and March 27th department meetings the Managers reinforced staff education regarding Consent to Blood Product Transfusion form completion, verification of Consent for Blood Administration and review of chart processing. The authorized healthcare employee will present verification of a valid order for blood transfusion and signed patient consent to the Blood Bank. Updated blood transfusion policies to include witness the consent, "Obtain a signed consent from the patient and witness the consent for administration of blood or blood products". The applicable departments will obtain employee signatures on education for blood transfusion process and policy addition. The Blood Bank in addition to the Order to Give Blood and the Report of Blood Transfusion, will now request verification of the patient's signed Consent to Blood Product</p>		

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	<p>were each administered without benefit of the patient's consent documentation form.</p> <p>Patient # 10 --Both units including unit# 1) given on 1/20/14 at 2248 and unit #2) given on 1/21/14 at 0210 were administered without benefit of a witness's signature on the patient's consent documentation form.</p> <p>3. On 3/03/14 at 1:30 p.m., staff member #9 acknowledged that each of the above-listed patients had received blood units without benefit of completed consent forms.</p>		<p>Transfusion. This will be monitored for 90 days. The Report for Blood Transfusion form has been updated with an addition under the Laboratory section "Blood Bank Form Verified" with check boxes "Consent" and "Order to Give" to be utilized as verification of the documentation at the time of blood transfusion. The Blood Bank will continue the retrospective monthly monitoring for deficient consents, as well as quarterly PIC reporting of deficient consents. Who is going to be responsible for this Tag: Director of Medical Records</p>		

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on medical record review, policy and procedure review, and interview, the nurse executive failed to ensure pain assessments were done according to policy and protocol for 11 of 20 patients seen in the Emergency Department (ED) (#N3, N5, N9, N13, N14, N15, N16, N17,</p>	S000912	<p><u>Failed to perform pain assessments according to policy/procedure on 11 of 20 ER patients</u> How are you going to correct the deficiency? All ER staff were educated on March</p>	03/27/2014			

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	<p>N19, N20, and N23).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The medical record for patient N3 indicated an ED visit on 12/07/13 for an ankle sprain and although a mark on the form was present on the ankle of the body diagram, the form lacked any other description or documentation of a pain assessment. 2. The medical record for patient N5 indicated an ED visit on 01/01/14 for foot pain, but the record lacked documentation of a pain assessment. 3. The medical record for patient N9, a 7-year old, indicated an ED visit on 03/10/13 for nausea, vomiting, and dehydration. The pain assessment form indicated a mark between 4 and 5 on the pain scale, but no further description or documentation on the form. 4. The medical record for patient N13, a 90-year old, indicated an ED visit on 12/13/13 for pneumonia and altered mental status. Nursing documentation indicated the patient was moaning, but unable to state where the pain is. The record lacked any further documentation of nursing evaluating pain with another pain scoring scale or system. 5. The medical record for patient N14, an 88-year old, indicated an ED visit on 12/12/13 for aspiration pneumonia. The pain assessment form indicated a mark on "no pain" on the pain scale, but with no further description or documentation on the form as to what scale was used since the patient was not communicating with staff. 		<p>27th at their unit meeting regarding pain assessments. This included the charting of full descriptions. All clinical staff is expected to perform a pain assessment during the initial nursing assessment, pre and post procedure (within 1 hour post intervention to include response of pain to procedure), upon discharge and PRN. How are you going to prevent the deficiency from recurring in the future? With an average of 1000 patients per month, the ER Nurse Manager will perform a randomized audit of a minimum of 10% of the ER patients monthly for one quarter with a goal of 90% compliance by the end of the quarter. Ongoing monitoring will then be done on a quarterly basis. The results will be reported quarterly at the hospital's PIC. Who is going to be responsible for this Tag: Chief Nursing Officer</p>				

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	<p>6. The medical record for patient N15, a 93-year old, indicated an ED visit on 01/19/14 for intracranial hemorrhage, but the record lacked documentation of a pain assessment.</p> <p>7. The medical record for patient N16 indicated an ED visit on 01/11/14 for headache, fever, and vomiting, and was subsequently transferred, but the record lacked documentation of a pain assessment.</p> <p>8. The medical record for patient N17 indicated an ED visit on 12/31/13 for rectal bleeding, but the record lacked documentation of a pain assessment.</p> <p>9. The medical record for patient N19 indicated an ED visit on 10/11/13 for pneumonia and a lung abscess, but the record lacked documentation of a pain assessment.</p> <p>10. The medical record for patient N20 indicated an ED visit on 10/18/13 for congestive heart failure and kidney disease, but the record lacked documentation of a pain assessment.</p> <p>11. The medical record for patient N23 indicated an ED visit on 10/07/13 for Crohn's disease and diarrhea and although a mark on the form was present on the abdomen of the body diagram, the form lacked any other description or documentation of a pain assessment.</p> <p>12. The facility policy "Pain Assessment", effective 04/19/2012, indicated, "Procedure: 1. During the assessment process, the clinician will provide and explain to the patient the pain management scale and will have the patient rate his/her pain. 2. Use Pain Rating Scale for assessment of pain, identifying which scale used: a. Wong-Baker Scale b. Numerical Scale c.</p>						

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S000936	<p>FLACC Scale. 3. Pain will be assessed at the beginning of each shift or procedure and regularly throughout the shift or procedure as indicated."</p> <p>13. At 11:00 AM on 03/05/14, staff member A8 confirmed the medical record findings and indicated pain should be assessed on all patients seen in the ED. He/she indicated there was no other pain policy specific to the ED and confirmed other pain scales should be used if the patient was not communicating.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(6)</p> <p>(b) The nursing service shall have the following:</p> <p>(6) All nursing personnel shall demonstrate and document competency in fulfilling assigned responsibilities. Based on personnel file review and interview, the facility failed to ensure 2 of 2 ED (Emergency Department) nurses had documentation of all required nursing competencies (#C3 and C4).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the personnel file for ED nurse C3, hired 06/10/13, lacked documentation of training or competency in medication, intravenous, and blood administration. Review of the personnel file for ED nurse C4, hired 12/03/12, lacked documentation of training or competency in medication, intravenous, and blood administration. At 12:50 PM on 03/05/14, staff member A8 	S000936	<p>Insufficient documentation of nurses' training How are you going to correct the deficiency? The two individuals whose files were missing documentation were completed on 3/27/2014 and documentation is in their Human Resource file. HR department has begun a retrospective audit of all nursing personnel's employee education files. Their findings will be reported to the Education Coordinator who will educate and document and update. How are you going to prevent the deficiency from recurring in the future? The orientation policy has been updated for the general</p>	03/27/2014

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	acknowledged all nurses should have competency in those skills and confirmed the lack of documentation for ED nurses C3 and C4.		nursing orientation, and will be attached to each departmental specific orientation policy. This will guide where, when, and how the orientation checklists are to be completed and stored. The Education Coordinator has created a general orientation checklist to standardize the orientation process across all nursing departments and nursing disciplines. Individual Education Records were updated to include blood and IV competencies. New hires will be monitored for 6 months by nurse managers for completeness of orientation checklists/competencies and the completed form will then be sent to HR to be placed in the individual's files. This will be reported to PIC. HR and nurse managers will monitor and nurse managers will report in PIC At the 3 month evaluation Nurse Managers will review the new employee's orientation checklist and place it in their HR file at that time. It will also be tracked by adding a check onto the 3 month evaluation. The Nurse Managers will report in PIC the percent of new employee's orientation checklist that are in their HR file by 90 days, which have been verified by HR. Who is going to be responsible for this Tag? Chief Nursing Officer	

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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 observation and staff interview, the hospital failed to ensure the Main Housekeeping Storage Room had an eye-washing system that meets the requirements of the chemicals that are used in the room.</p> <p>Findings included:</p> <p>1. At 3:05 PM on 3/4/2014, the Main Housekeeping Storage Room was inspected. The room contained assorted gallons of Lime-away, Vertex Bleach. Floor cleaner, etc. The gallons are poured into the battery operated floor scrubber and mop buckets. The labels on the gallon</p>	S001118	<p>Eyewash station in environmental cabinet empty and leaking. How are you going to correct the deficiency? On Tuesday March 4th, 2014, immediately following the facility tour the eye wash solution canister was replaced with a new canister. A new plumb eye wash station will be installed on April 4th. How are you going to prevent the deficiency from recurring in the future? We will be replacing the self contained eyewash station located in the janitors store room with a permanently fixed eyewash station that is connected to domestic tepid water source that can provide constant and continuous flow of water on April 4th. Eyewash stations in the facility will be inspected weekly by the Director of Facility Services or his designee. Compliance will be reported quarterly at PIC for a minimum of one year. Who is</p>	04/04/2014			

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	<p>containers notes in case the chemicals come in contact with the user's eyes; flush the eyes with a steady stream of water for at least 15 minutes. The portable eyewash system that was on the wall was leaking on to the floor and it was empty during the inspection. However, the refillable cartridges for the portable eye wash system can only flush a person's eyes for 5 to 10 minutes if it was full. Therefore, the room did not have an adequate eyewash system to meet the first aid emergency requirements of the chemicals that are used in the room.</p> <p>2. At 3:15 PM on 3/4/2014, staff member #7 confirmed the portable eyewash system was leaking on to the floor and it was empty during the inspection. The staff member confirmed the portable system mounted on the wall cannot flush a person's eyes for at least 15 minutes in case of an emergency.</p>		going to be responsible for this tag? Director of Facility Services				

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S001160	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on documentation review and staff interview, the hospital failed to comply with Surgery Department's Operating Room's humidity 35-66% humidity range for Extension offsite.</p> <p>Findings Included:</p> <ol style="list-style-type: none"> Gibson General Hospital Surgery Department Daily Temperature and Humidity Check Form indicates to contact Maintenance if the temperature or humidity is outside of the ranges: Temperature 60-72 F; Humidity 35-66%. The check form indicated to document occurrences on back of the form. Gibson General Hospital Surgery Department Daily 	S001160	<p>Humidity out of range at the Surgery Extension building How are you going to correct the deficiency? On March 13, 2014, Alpha Mechanical (a contractor) recalibrated the humidity control at the Surgery Department Extension building to maintain the humidity in the proper range of 35 – 66%. The calibrations are validated daily during the humidity checks. How are you going to prevent the deficiency from recurring in the future? Continue to monitor the humidity at the Surgery Department Extension building on a daily basis in the two operating suites. If the humidity is ever found to be out of range, a work order will be completed for maintenance to immediately follow-up. The Surgery Director records the humidity on the monitoring forms which are forwarded to Facilities for tracking purposes. Adjustments will be made by the maintenance department in the building automation system as needed to compensate for any deficiencies. The humidity compliance will be</p>	03/13/2014			

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	<p>Temperature and Humidity Check Form for January and February 2014 revealed Operating Room #1 was 39 out of 42 days noted the humidity to be less than 35%. The check form for Operating Room #2 was 35 out of 42 days noted the humidity to be less than 35%. Neither the January or the February forms documented any occurrences on back of the forms.</p> <p>3. At 1:15 PM on 3/4/2014, staff member #7 indicated Extension offsite complex was bought recently and added to the hospital license. Staff member #7 indicated the Surgery Department staff notified the Maintenance Department of the humidity level in both operating rooms are not reaching the required 35% humidity range. However, the Maintenance Department cannot change the humidity controls without contacting an outside vendor.</p>		<p>reported to PIC on a quarterly basis for one year through the surgery department's QA report. Who is going to be responsible for this tag? Director of Facility Services</p>		

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S001162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on document review, the facility failed to comply with manufacturer recommendations for 2 of 2 Hydrocollators in the Rehabilitation Department.</p> <p>Findings included:</p> <p>1. The Operation Manual instructions for the use and operation for Rehabilitation Department's 2 Hydrocollator M-2 Master Heating Units notes the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The</p>	S001162	<p>Rehab dept Hydrocollator M-2 Master Heating Units temperatures out of range How are you going to correct the deficiency? The hydrocollators temperatures were adjusted to reflect the Operation Manual instructions for use and operation which identified the recommended operating temperature (160 -166 degrees F). Monitoring began with new norms on the updated/corrected temperature log. Department Director updated/corrected policies and procedures to reflect the new normal temperature range of 160-166 degrees F. These items were completed on March 6, 2014. How are you going to prevent the deficiency from recurring in the future? March 18, 2014 staff educated on the</p>	03/18/2014			

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	<p>recommended operating temperature was 160 to 166 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs.</p> <p>2. The Rehabilitation Department Hydrocollator M-2 Master Heating Unit February 2014 temperature log revealed the water exceeded 166 degrees Fahrenheit for 19 of 19 days each for the 2 Hydrocollator's temperatures that were recorded exceeded 166 degrees Fahrenheit. The Daily Temperature Log noted at the bottom of the form the Hydrocollator's temperature should be between 165 and 180 degrees Fahrenheit which exceeded the manufacturer's recommendations.</p>		<p>new temperature ranges at the departmental/staff meeting. Director of Rehab and/or delegated staff member will monitor/track hydrocollators temps daily and report on quarterly at PIC. Who is going to be responsible for this tag? Director of Rehabilitation Services</p>		

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(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			
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 and staff interview, the hospital failed to ensure the Rehabilitation Department's Whirlpool Room was maintained clean and organized.</p> <p>Findings included:</p> <p>1. At 2:20 PM on 3/4/2014, the Rehabilitation Department's Whirlpool Room was inspected. The room was observed with 12 assorted sizes of shipping boxes stored on the whirlpool and a</p>	S001172	<p>Rehab dept whirlpool room: outside shipping boxes How are you going to correct the deficiency? All outside shipping boxes were removed on March 5th from the whirlpool room and all supplies are stored in cabinets where they will continue to be stored. How are you going to prevent the deficiency from recurring in the future? Rehab staff were educated during the staff meeting on 3/18/14 and instructed to not use shipping boxes for any stored items in the future. Director and designee of the department will monitor the whirlpool room routinely to ensure that shipping boxes are not stored in room. Rehab dept whirlpool room: dust, debris, unorganized,</p>	03/25/2014			

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	<p>chair along the wall. The counter in the room was observed soiled with dust and a white powder substance. The floor was observed soiled with heavy accumulation of dirt and other debris. Under the wound exam table, a long loose gray wire was observed. The exam table was observed with loose debris on it. The room was set up for patients to use; however, the room's overall appearance was not clean and organized.</p> <p>2. At 10:30 AM on 3/5/2014, staff member #7 indicated the Whirlpool room was for patients who need wound care. The assorted boxes in the room were Wound Vac Dressings. The staff member indicated the department does not have an area to store the boxes and thought it was acceptable to store them on the whirlpool which was not in use anymore. The staff member confirmed the room was needing some cleaning done to it.</p>		<p>gray cord on floor under table. How are you going to correct the deficiency? The whirlpool room will be cleaned daily with cleaning documented on a tracking log daily by the environmental service staff. Maintenance recaulked the corner of the countertop on 3/25/14. The only gray cord in the whirlpool room was connected to the large whirlpool tub. This cord was unplugged from the wall and secured to the machine using a twist tie to keep it off the floor. How are you going to prevent the deficiency from recurring in the future? Environmental services (EVS) re-educated their staff at the March 24th department meeting on proper cleaning procedures including sweeping floor and wiping and cleaning of all countertops in the whirlpool room daily. Staff will sign off on the training. A tracking log will be kept in the EVS Manager's office. Rehab Director and designee will monitor the whirlpool room to ensure that shipping boxes are not used to store items and that the gray cord is secured with a twist tie when not in use. EVS Manager will keep a daily tracking log for whirlpool room cleaning. This will be reported quarterly to PIC. Who is going to be responsible for this tag? Director of Rehabilitation Services</p>				

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