STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151333	A. BUILDING 00 B. WING	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUTNAM COUNTY HOSPITAL	1542 S BLOOMINGTON ST GREENCASTLE, IN 46135

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S000000	This visit was for a standard licensure survey. Facility Number: 004765 Survey Date: 6-25/28-12 Surveyors: Jack I. Cohen, MHA Medical Surveyor Deborah Franco, RN Public Health Nurse Surveyor Cleone Peterson Medical Surveyor QA: 07/06/12	S000000		
S000308	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (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:			

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

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	(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on document review and interview, the facility failed to document 2 of 12 employees were oriented to applicable facility policies. Findings: 1. Review of HOSPITAL REGULATION 40-14, section entitled ORIENTATION SESSION, reviewed 12-20-11, indicated all new employees will be scheduled for orientation. 2. Review of 12 personnel files indicated files PF#4 and PF#10, contracted employees, did not contain any documentation of orientation to applicable facility policies 3. In interview, on 6-28-12 at 11:30 am, employee #A1 indicated there was none of the above documentation and none was provided prior to exit.	S000308	**S308** **Plan of Correction**: #2 – The HR Coordinator will review and audit all contracted employee personnel files. Any contractor who has not attended a facility orientation will be scheduled to do so. **6/28/12 – 7/28/12** · 7/20/12: Met with Tx Team Manager to discuss required items contractor files must contain · 7/20/12: E-mail sent to all Managers notifying the necessity to notify HR of any contractor within each department and personnel file requirements **7/29/12 – 8/29/12** · File audit to be completed · Facility Orientation completed for any contractor who has not previously attended.	07/20/2012

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			Date of Completion: **07/20/12** **Responsibility:** **HR Coordinator** **Prevent Recurrence**: The HR Coordinator will track receipt of documentation for contractor orientation. If documentation is not received in a timely manner, the HR Coordinator will contact Department Manager to ensure the orientation is scheduled and completed.	
S000312	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D) (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: (D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on document review and	S000312	**S312**	07/20/2012

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	interview, the facility failed to conduct, per policy, a performance evaluation for 2 of 10 employee files reviewed. Findings: 1. Review of HOSPITAL REGULATION 30-16, entitled ANNUAL EVALUATION PROCEDURE, reviewed 12-20-11, indicated the annual evaluations is due during the month of the employee's position entry date (the date an employee begins in a particular position). 2. Review of 10 personnel files indicated files PF#4 and PF#10 did not contain any documentation of performance evaluation conducted by the facility. The file contained performance evaluations done by an individual employed by the contractor. Review of the contract between the hospital and the contractor did not indicate the hospital gave the contractor the right to perform the evaluation. Also, review of the evaluation did not indicate an authorized individual from the hospital had reviewed and dated the review of the evaluation. 3. In interview on 6-28-12 at 11:30 am, employee #A1 indicated the evaluation was done by an individual not authorized by the hospital. The employee also		**Plan of Correction** The HR Coordinator will review and audit all contracted employee personnel files to assure each evaluation is current and has been reviewed and approved by the authorized individual of the hospital (CEO). **6/28/12 – 7/28/12** · 7/20/12: Met with Tx Team Manager to discuss required performance evaluations and reviewed for any delinquencies. · 7/20/12: E-mail sent to all Managers notifying the necessity to notify HR of any contractor within each department and personnel file requirements **7/29/12 – 8/29/12** · File audit of all contractor files reviewed for delinquencies · All Contractor Performance Evaluations review and approved by the authorized individual of the hospital (CEO). **Completion Date: 07/20/12** **Responsibility:** **HR Coordinator**	

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	indicated there was no contractual right given to the contractor to perform the evaluation, and the evaluation did not have documentation an authorized individual from the hospital had reviewed and dated it. No further documentation was provided none was provided prior to exit.		**Prevent Recurrence**: For each contracted employee, department manager will provide timely annual performance evaluations and forward to HR Coordinator for Personnel file record. The HR Coordinator will do an annual review of the contractor personnel files to ensure receipt of annual performance review. **New Procedure Added**: All contractor performance evaluations will be reviewed and approved by the authorized individual of the hospital (CEO).	
S000318	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F) (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: (F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice			

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	and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice for 2 of 6 health care workers who provide direct patient care. Findings: 1. Review of HOSPITAL REGULATION 30-14, entitled C.P.R. TRAINING, reviewed 12-20-11, indicated cardiopulmonary resuscitation training for personnel in the following departments shall be conducted at least bi-annually: All direct patient care departments. 2. Review of 6 personnel files indicated files PF#4 and PF#12. Each file contained documentation from an organization which offered a CPR course. Review of the documentation did not indicate the course included a competency (hands-on demonstration) component. 3. In interview, on 6-27-12 at 11:55 am,	S000318	**S 318** **Plan of Correction**: The HR Coordinator will review and audit all direct patient care provider personnel files to ensure C.P.R. certification is current and from an organization which provides hands-on competency demonstration, specifically American Heart Association or American Red Cross. **6/28/12 – 7/28/12** · 7/25/12 – Hospital Regulation 30-14, entitled C.P.R. Training revised and sent to all department managers **7/29/12 – 8/29/12** · HR Coordinator to Review and Audit all direct patient care provider personnel file to ensure C.P.R. certification is current and from an organization which provides hand-on competency demonstration, specifically American Heart	07/25/2012

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	employee #A1 indicated the organizations' training was on-line only and did not include a competency component. No further documentation was provided prior to exit.		Association or American Red Cross. Any associate found deficient will be notified to complete training. **8/30/12 – 9/30/12** · Receipt from all direct patient care providers current certification of completion of required C.P.R. training **Completion Date: 07/25/12**. **Responsibility:** **HR Coordinator** **Prevent Recurrence**: The only accepted C.P.R. training will be from the American Heart Association or American Red Cross, which provide hands-on competency demonstration. **See Attached Exhibit S 318-1**	
S000330	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K) (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: (K) Maintaining personnel records for			

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	each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable. Based on document review and interview, the hospital failed to maintain personnel records for 3 of 12 personnel records reviewed which included evidence of participation in job related educational activities. Based on document review and interview, the hospital failed to maintain personnel records for 2 of 12 personnel records reviewed which included evidence of a two step tuberculosis/protein prepared derivative (TB/PPD) screening Findings: 1. Review of HOSPITAL REGULATION 4-14, Section entitled ORIENTATION SESSION approved 5-25-11, indicated yearly, all employees will be reviewed on Infection Control-Personal Hygiene, Disaster procedure, Fore Plan Procedures, Body mechanics - Back Care, Safety Regulations and Hazardous Waste Information, as is appropriate for their	S000330	**S330** **Plan of Correction**: #2 – The HR Coordinator will review and audit all employee personnel files. Any employee who has not attended an annual In-Service orientation will be scheduled to do so. **6/28/12 – 7/28/12** · Reports ran from HRIS Access database for list of delinquent annual In-Service · Determination of inaccurate data in HRIS Access database. **7/29/12 – 8/29/12** · Review and audit all employee personnel files. Any employee who has not attended an annual In-Service orientation will be scheduled to do so. **8/30/12 – 9/30/12** · Any associate who was	07/26/2012

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	work place. 2. Review of 12 personnel files indicated files PF#4, PF#10 and PF#12 did not have current documentation of a yearly review on the above-stated subjects. 3. In interview, on 6-28-12 at 11:30 am, employee #A1 indicated the above-stated documentation was not available and no further documentation was provided prior to exit. 4. Review of hospital policy NO. EH-4, entitled POST-OFFER HEALTH ASSESSMENT AND DRUG SCREENING, approved 5-25-11, indicated the health assessment includes a two-step TB/PPD screening unless there is a reported positive history for PPD screening. 5. Review of 12 personnel files indicated files PF#2 and PF#11 had no documentation of either a two-step screening nor a report of positive history for PPD screening. 6. In interview, on 6-28-12 at 11:30 am, employee #A1 indicated neither the PPD creeping nor report of history was available and no further documentation was provided prior to exit.		found to be delinquent will have completed their annual In-Service and documentation of such will have been forwarded to HR for placement in the associates' personnel file. . **Completion Date: 07/26/12** **Responsibility: HR Coordinator** **Prevent Recurrence**: The HR Coordinator will track receipt of documentation for facility Annual In-Service. If documentation is not received in a timely manner, the HR Coordinator will contact Department Manager to ensure the orientation is scheduled and completed. Tag #S330 #4: EH TB/PPD Screening **Plan of Correction:** **6/28/12-7/28/12:** 1. 7/23/12: Completion of Employee Health File audit regarding completion of 2-step PPD. **7/29/12-8/29/12:** 1. Letters will be sent to employees notifying them of their need to schedule a date and time for PPD placement within 30 days. 2. Department Managers will be	

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			notified and provided a list of their employees who are in need of completing this employee health requirement. 3. On 8/22/12 the EH Nurse will report Employee File PPD Audit to the Infection Control Committee. **8/30/12-9/30/12:** All associates/contract associates will have completed the 2-Step PPD EH requirement. **Prevention:** 1. To prevent this deficiency from recurring, the Employee Health Nurse will set a separate appointment for new employees regarding their 2 nd step PPD placement within 1-3 weeks post-employment. **Responsibility:** The Employee Health Nurse and/or designee will be responsible for tracking the 2 step PPD process. Also, the employee's Department Manager will be a partner, ensuring that the employee is able to leave the floor for a few minutes for PPD placement. **Date of Completion:** **07/23/2012**	
S000871	410 IAC 15-1.5-5 Medical Staff 410 IAC 15-1.5-5(b)(3)(O) (b) The medical staff shall adopt and enforce bylaws and rules to carry out			

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	its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following: (O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual receiving a verbal order shall date, time, and sign the verbal order in accordance with hospital policy. Authentication of a verbal order must occur within forty-eight (48) hours unless a read back and verify process described under items (i) and (ii) is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge. (i) As an alternative, hospital policy may provide for a read back and verify process for verbal orders. Any read back and verify process must require that the individual receiving the order shall immediately read back the order to the ordering physician or other responsible individual who shall immediately verify that the read back order is correct. (ii) The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. Where the read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge. Based on document review and interview, the facility failed to implement its policy requiring verbal and telephone orders be documented in the medical record as read-back to	S000871	Tag # S 871: Read Back Orders **Plan of Correction:** **6/2812-7/28/12:** Educate nursing staff on Read Back Orders (RBO) for all Telephone/Verbal orders, verifying that the documentation	07/18/2012

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	assure correctness, for 4 of 30 medical records reviewed (N5, N6, N9, and N20). Findings included: 1. Facility policy " Physicians Orders " , last reviewed/revised July 2011, page 1, item 3, required " Telephone and verbal orders ...must be read back to the physician to assure correctness " and " ...must be signed, dated, and authenticated by the ordering physician within 24 hours " . 2. Review of medical record of N5 indicated a telephone order on 5-30-2012 for " Levaphed 10 mcg/min-titrate for SBP> 90 " which lacked documentation that the order had been read back to assure correctness. 3. Review of medical record of N6 indicated a telephone order on 2-15-2012 to " Anchor foley, Change IVF to KVO " which lacked documentation that the order had been read back to assure correctness. 4. Review of medical record of N9 indicated a telephone order on		is correct as per Policy # 100-40. (both on paper and in the EMR.) 7/18/12: Posted on Units and placed in each Unit Communication Book and E-mailed to all ICU/Med-Surg Staff – A. Staff meeting notice on 7/31/12 to discuss compliance with Policy #100-40, Read Back Orders (RBO), and B. Memo dated 7/17/12 regarding Read Back Orders and process to document verification on paper and EMR. Adherence to Policy 100-40 is immediate. C. Completion of 2 nd Quarter RBO Audit – ICU 93% and Med-Surg 88%. **7/29/12-8/29/12:** 7/31/12: Staff meeting to address and reinforce compliance with Policy 100-40, Read Back Order procedure. 8/3/12: Report 2 nd Quarter Statistics to Department of Medicine Committee **8/30/12 – 9/30/12:** Continue to perform monthly chart audit for third quarter. **10/1/12-11/1/12:** 10/15/2012: Complete third quarter chart audit. If Third Quarter Statistics reveal compliance rate of < 100%, a Performance Improvement Plan will be initiated. **11/2/12-12/2/12:** On 11/2/12 the ICCU/Med-Surg Managers will report the 3 rd Quarter Statistics to the Department of Medicine. **Prevention:** Continue to perform monthly random chart audit and report quarterly to Department of Medicine. **Responsibility:** Denise Stepro, RN and Kammie	

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	4-12-2012 for " FSBG monitoring, Humalog insulin at low dose protocol " which lacked documentation that the order had been read back to assure correctness. 5. Review of medical record of N20 indicated a telephone order on 5-14-2012 for " Resume previous IVF and rate " which lacked documentation that the order had been read back to assure correctness. 6. During interview with S2 on 6-27-2012 at 9: 45 AM, S2 verified the above findings in the medical records and confirmed that the documentation was not in accordance with facility policy.		Meek, RN, Nursing Managers. **Date of Completion:** 07/18/2012: **Exhibits for Tag # S 871** 1. E-mail from D. Stepro to nursing staff re: staff meeting on 7/31/2012. 2. 7/17/12 Memo re: Telephone/Verbal orders	
S000932	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized			

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	plan of care based on standards of care for each patient. Based on document review and interview, the nursing staff failed to assure individualized nursing plans of care for 8 of 30 medical records reviewed (N15, N17, N18, N19, N20, N21, N22, and N25). Findings included: 1. Facility policy " Charting " , last reviewed/revised July 2011, page 1, C, 1, required " Nursing care plan must be initiated in first 8-24 hours of admission". 2. Review of the medical records of N15, N17, N18, N19, N20, N21, N22, and N25 lacked documentation of a nursing care plan implemented at any time during the patients' admission. 3. During interview with S2 on 6-27-2012 at 9:45 AM, S2: a. verified the above findings in the medical records. b. confirmed the lack of nursing care plans in the medical records was not in conformance with facility policy. c. indicated the facility had	S000932	Tag # S 932: Care Plans **Plan of Correction:** To ensure that care plans are initiated, reviewed and updated as per the Nursing Charting Policy # 100-28. Continued education and monitoring of documentation to occur. **6/28/12-7/28/12:** · 7/1/12: Meaningful Use Checklist initiated that EMR Superusers are using to audit open records - the care plan is a part of that daily checklist. If found to be non-compliant, the Superuser alerts the appropriate nurse to initiate and/or review the patient's plan of care. · 7/9/12: Charge Nurse Duties checklist initiated. Charge nurse is responsible to check or delegate duty of checking patient care plans to verify compliance as per policy. · 7/18/12: E-mailed all ICU/Med-Surg staff with Memo re: Care Plans/Problem List, checklists, and upcoming Staff Meeting on 7/31/12. Posted Memo on units and placed in Unit Communication Book as well. **7/29/12-8/29/12:** · 7/31/12: Staff meeting to reinforce the importance of patient care plan development and review, compliance with Nursing Policy #100-28. · Continue to monitor progress as provided by daily checks.	07/18/2012

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	converted to electronic medical records (eMR) within the last 6 months. d. stated that the facility QA process had detected the problem of lack of documentation of nursing care plans in the eMR and that a performance improvement plan had been implemented.		**8/30/12-9/30/12:** · 9/30/12: End of third quarter – managers to gather and compile data. **10/1/12-11/1/12:** · 10/10/2012: Evaluation of Third Quarter Statistics and Re-evaluation of improvement initiatives to achieve compliance of 90% or greater. **11/2/12-12/2/12:** On 11/2/2012 the ICCU/Med-Surg Managers will report the Third Quarter Statistics to the Department of Medicine. **Prevention:** Continue to audit charts monthly and report quarterly to Dept. of Medicine. Re-evaluate performance improvement initiatives quarterly to ensure positive progress. **Responsibility:** Denise Stepro, RN and Kammie Meek, RN, Nursing Managers to complete monthly chart audits and report quarterly statistics to Department of Medicine. **Date of Completion:** 7/18/2012 **Exhibits for Tag # S 932** 1. E-mail from D. Stepro to nursing staff re: staff meeting on 7/31/2012. 2. Memo7/16/12 – "Problems" re: Care Plan 3. Charge Nurse Duties Checklist, sample dated 7/21/12 4. Meaningful Use Daily	

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			Checklist, sample Med-Surg Department dated July 1 & July 2, 2012 5. Meaningful Use Daily Checklist, sample ICCU Department dated July 24 & July 25	
S000952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to administer 2 of 7 transfusions in accordance with state law and/or approved medical staff policies and procedures. Findings included: 1. Review of Putnam County Hospital procedure for Blood Transfusion 100-36 E last revised 3/2006 and reviewed 1/11/2012 revealed: "Complete transfusion sheet filling in all blanks as directed." 2. Transfusion Record review performed on 6/26/12 between 10:30 a.m. and 12:30	S000952	Tag S 952 Blood Transfusions **Plan of Correction: a)** Blood transfusion sheet will have all areas completely filled in as verified by 2 nd signature on the form. **b)** Physician's written or verbal order will be obtained prior to administering blood. **6/28/12-7/28/12:** · 7/18/12: Email to staff from Denise Stepro, RN, ICCU/Med Surg Nursing Manager informing Staff about scheduled staff meeting to discuss Blood Transfusion documentation issues. · 7/19/12: Staff memo posted in units and placed in unit communication books re: need for physician's order and patient consent signed prior to transfusion	07/20/2012

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	p.m. revealed: a. Transfusion #1 had crossed out and incomplete documentation on the transfusion sheet mentioned in the above approved policy/procedure for transfusion administration. b. Transfusion #6 had no doctor's order as required by the state of Indiana to give the transfusion. There appeared to be an order in the nurses' notes but it was lined out, and there was no explanation as to why this occurred and no other valid order was available. 3. In interview on 6/26/12 between 11:30 a.m. and 12:30 p.m. staff person #1 acknowledged the above documentation problems.		administration, and completion of blood transfusion form. · 7/20/12: Denise Stepro, RN and Kammie Meek, RN, ICU/Med-Surg Nursing Managers and Lab Manager, Ron King met to discuss improvement activities that would affect documentation compliance. **7/29/12-8/29/12:** · 7/31/2012: Mandatory staff meeting to discuss changes to improve compliance. · Continue to work on July and August transfusion record audits. **8/30/12-9/30/12:** · On 9/12/2012: July & August Statistics to be reported to Pharmacy & Therapeutics Committee. If compliance <100% a Performance Improvement Plan will be initiated to begin 10/1/2012. **Prevention:** 1. Education to staff. 2. Blood Bank Form Audit to be completed monthly and reported quarterly to the Pharmacy & Therapeutics Committee. 3. Random chart audit for Transfusion Order to be completed monthly and reported quarterly to the Pharmacy & Therapeutics Committee. **Responsibility:** Ron King, Lab Director will complete 100% of audits on blood transfusion charts. **Date of completion:** 7/20/2012 **Exhibits:** 1. Email to staff on 7/18/2012 informing of staff meeting 7/31/2012. 2. Memo dated 7/19/2012	
S000954	410 IAC 15-1.5-6 NURSING SERVICE			

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	410 IAC 15-1.5-6(e) (e) Emergency equipment and emergency drugs shall be available for use on all nursing units. Based on observation, document review, and interview, the facility failed to assure availability of emergency equipment on the pediatric crash cart on one (1) of two (2) inpatient units (Medical/Surgical) toured. Findings included: 1. During tour of the 4 South medical/surgical unit, which served both adults and pediatric patients, it was observed that the pediatric crash cart did not have a cricothyrotomy kit available for use. 2. The " Pediatric Crash Cart List " on the pediatric crash cart of the 4 South medical/surgical unit, review/revision date not on the document, required a Pediatric Cricothyrotomy kit be available on the top of the cart. 3. During interview with S1 on 6-25-2012 at 10:30 AM, S1 indicated: a. the staff are to stock the pediatric crash cart according	S000954	Tag # S 954: Crash Carts **Plan of Correction:** a,b,c: **6/28/12-7/28/12:** · 6/29/12: A Pediatric Cricothyrotomy Kit was placed on the pediatric crash cart. · 7/9/12: Charge Nurse Duties checklist initiated. Charge Nurse is responsible to complete or delegate crash cart review. · 7/18/12: E-mailed all ICU/Med-Surg Staff re: staff meeting on 7/31/12 & Charge Nurse Checklist. · 7/19/12: Memo to staff regarding check crash cart inspection and documentation. Posted on units and placed in unit communication book. · 7/20/12: Revision to Nursing Policy 100-21A, Crash Carts. Development of Nursing Policies 100-21B , Adult Crash Cart Medication/Equipment List and 100-21C, Pediatric Crash Cart Medication/ Equipment List. **7/29/12-8/29/12:** · 7/31/12: Staff meeting will address importance of checking crash cart and making sure all supplies are present. Review of Nursing Policies, 100-21A, 100-21B and 100-21C. · 8/3/12: Nursing Policies to be presented for approval at the Department of Medicine Committee. **8/30/12-9/30/12:** · Continue to monitor progress of compliance with third quarter ending 9/30/12.	07/20/2012

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	to the list on the cart and that regardless of lack of policy or date on the document that the pediatric cricothyrotomy kit was to be stocked. b. a pediatric cricothyrotomy kit is a piece of emergency equipment that should be immediately available in the event of a code for a pediatric patient. c. a facility policy was requested during the survey regarding a recently reviewed/revised list of emergency drugs and emergency equipment for crash carts, but none was provided prior to exit.		**10/1/12-11/1/12:** · 10/15/2012: Review of 3 rd Quarter Statistics. If compliance is = 95% a Performance Improvement Plan will be initiated. **11/2/12-12-2/12:** · On 11/2/12 the ICCU/Med-Surg Nursing Managers will present the 3 rd Quarter Statistics to the Department of Medicine. **Prevention:** Monitor monthly compliance and report results quarterly to Dept. of Medicine. Annual review of Nursing Policies. **Responsibility:** Denise Stepro, RN and Kammie Meek, RN, ICU/Med-Surg Nursing Managers are responsible for the audit and quarterly reporting of this monitor to the Department of Medicine. Joni Perkins,RN, Director of Nursing is responsible for making sure that all Nursing Policies/Procedures are reviewed and updated annually. **Date of Completion: 7/20/2012 Exhibits for Tag # S954 1. E-mail from D. Stepro to nursing staff re: staff meeting. 2. 7/19/12 Memo 3. Charge Nurse Duties Checklist, sample dated 7/21/12 4. Nursing Policy 100-21A, Emergency Equipment. 5. Nursing Policy 100-21B, Adult Crash Cart Medication/Equipment List 6. Nursing Policy 100-21C, Pediatric Crash Cart Medication/Equipment List**	
S001022	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES			

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	410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. Based on observation, document review, and interview, the surgical services department failed to assure that medications were stored under appropriate conditions per facility policy for one (1) of three (3) medication refrigerators observed (Surgical Services Anesthesia Closet) . Findings included: 1. During tour of the surgical services department on 6-26-2012 at 11:10 AM and in the presence of S3, the Anesthesia Closet medication refrigerator containing anectine, protamine, and other anesthesia related drugs was inspected and the temperature log for June 2012 was reviewed. a. The log form noted that acceptable temperature range for medications was 36-46 degrees Fahrenheit. b. The log contained eleven (11) dates where the temperature was below 36	S001022	S 1022 Correction:1. The temperature log (see attached) has been modified to increase compliance and add accountability to document interventions when the temperature is out of range. The log now includes the phone numbers for maintenance and pharmacy departments to increase follow through when temperature is out of range. The log also has a space to check if the maintenance and pharmacy departments have been notified. Finally, the log has been modified to include a section for rechecked temperatures and what actions have been taken by nursing staff. Prevention:2. The new log will be highlighted at the next unit meeting and the staff educated on its appropriate use. Further, the team leader of surgery, Deborah Miller, will do weekly checks on the log. The log will be returned monthly to pharmacy where the Director of Pharmacy will check the log for completeness. Responsibility:3.	08/01/2012

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	degrees Fahrenheit. c. The log lacked documentation that the unacceptable temperatures had been reported to the supervisor, the maintenance department, or pharmacy. d. Three (3) of the entries had an adjustment made to the temperature when it was recorded as 28 or 30 degrees but lacked any further follow up to assure correct temperature storage of the medications. 2. Facility policy " Quality Control-Drug Storage Areas-Monthly Inspections", last reviewed/revised 3-9-2011 provided on page 2, item 7 "All refrigerators, freezers, and warmers where medications are stored throughout the hospital shall have their temperatures checked daily... The refrigerator temperature shall be maintained between 36 and 46 degrees Fahrenheit... If temperature is identified outside the designated range, the Maintenance Department and Pharmacy must be notified immediately". 3. During interview with S3 on 6-26-2012 at 11:10 AM, S3 confirmed that the medications in the refrigerator had been kept at an unacceptable temperature for at least 18 consecutive days without appropriate follow-up reporting by staff or correction of storage temperature of the medications as		The surgery team leader and Director of Pharmacy will be responsible for monitoring the completeness and accuracy of the log. Completion:4. The new log and education will be implemented at the next department meetings at the end of July and first of August. Exhibits:1. Temperature Log - Pacu2. Temperature Log - Anesthesia Closet3. New Medication Temperature Record	

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	required by facility policy.			
S001028	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on observation, document review, and interview, the facility failed to assure the security and access by authorized personnel only for 3 of 7 crash carts inspected (2 in ICU, 1 on Medical/Surgical unit) Findings included: 1. During tour of the facility on 6-26-2012 at 11:40 AM in the presence of S2, the adult and pediatric crash carts and their logs	S001028	S1028 Plan Of Correction:1. Pharmacy policy (Sec VI-M: "Medication Distribution – Emergency Medication Supplies" – item 3) has been adjusted to include use of temporary locks (numbered yellow plastic tags) for nursing staff to lock the crash cart after opening for any reason (amended policy attached). Nursing services policy (100-21a: Emergency Equipment crash cart/defibrillator/oxygen cylinders) has also been amended to include these changes (policy attached). The yellow locks will	07/31/2012

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	were inspected in the ICU. a. The adult crash cart log indicated that it had not had a plastic lock on the cart for 16 shifts (including 3 consecutive days June 3 to 6) during the month of June 2012. b. The adult crash cart log indicated that it had not had a plastic lock on the cart for 12 shifts (including 3 consecutive days May 25 to 28) during the month of May 2012. c. The pediatric crash cart log indicated that it had not had a plastic lock on the cart for 19 shifts (including 3 consecutive days June 4 to 7) during the month of June 2012. 2. During tour of the facility on 6-25-2012 at 11:00 AM in the presence of S2, the adult crash cart and log was inspected on the Medical/ Surgical unit and the adult crash cart log lacked documentation that it had a plastic lock on the cart for 15 shifts during the month of June 2012. 3. Facility policy " Crash Cart " , last reviewed/revised June 2011, page 1, required " All crash carts in the hospital will be secured with a		be stored in the Omnicell unit, so a tracking system for whom is pulling the locks can be implemented. Nursing will contact pharmacy whenever a yellow lock is placed on the crash cart. In accordance to policy, only pharmacy staff will place a permanent lock (numbered purple locks). A log for the number and location of the permanent lock will be kept in pharmacy (see attached). This will be implemented as soon as pharmacy staff can obtain the numbered yellow locks from their supplier. Prevention:2. By making the temporary locks available to nursing, no crash cart should go unlocked for any length of period. Crash cart checks with each shift will record the type of lock on the cart and notification to pharmacy for permanent lock, if a yellow lock is on the cart and the cart has been restocked by nursing. Team leaders for all locations with a crash cart will spot check the log. The Director of Pharmacy will check the log for permanent locks kept in pharmacy. Each department will be educated at their next department meetings. Responsibility:3. Team leaders for areas with crash carts will be responsible that nursing is using the temporary locks as described in the policy. Director of Pharmacy will be responsible for ensuring pharmacy staff is recording permanent lock	

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	numbered plastic seal lock " and " There will be an inspection log on each crash cart and the integrity of the lock will be checked and documented every 8 hours " . 4. During interview with S2 on 6-26-2012 at 11:40 AM, S2: a. verified the above findings regarding the lack of documentation of locks for the crash carts in ICU and the crash cart on the Medical Surgical unit. b. confirmed that the log records were not kept in accordance with facility policy for the secured storage of medication. c. indicated that the unit staff or pharmacy staff should have secured the crash cart each shift and documented the locked status of the cart on the logs; that there was no reason to leave a crash cart open for more than the few minutes it would take to restock; and that unlocked carts are not safe and provide unauthorized access opportunities.		numbers before locking crash carts. Date of Completion:4. The updated policy will be implemented as soon as materials arrive and staffs are educated. This will likely occur by the end of July.Exhibits:1. Crash cart lock sign-out sheet.2. Nursing policy 100-21a3. Pharmacy Policy - Medication Distrubution / Emergency Medication Supplies	
S001118	410 IAC 15-1.5-8 PHYSICAL PLANT			

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	410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on document review, observation and interview, the hospital created conditions which resulted in a hazard to patients, public or employees in 1 instance and failed to assure the safety of patients by not removing outdated supplies (1 of 5 units toured) and by not monitoring the temperature of a blanket warmer (1 of 5 units toured). Findings: 1. Review of of hospital policy # 40-6, entitled GAS CYLINDERS - NON FLAMMABLE ANESTHETIC, reviewed 12-20-11, indicated all gas cylinders must be secured by chain or other measures so as to prevent accidental tipping. 2. On 6-25-12 at 2:30 pm in the presence of employees #A1 and #A8, it was observed in the maintenance Shop, there	S001118	S 1118 **Plan of Correction:** 1. Extinguisher secured immediately with approved methods by Jody Fox; Director of Plant Operations **Prevention:** 2. Securing of cylinders added to "Putnam County Hospital Safety Hazards Inspection" on July 16, 2012 3. "Securing Gas Cylinders" added to Maintenance Department Policy and Procedures, July 16, 2012 4. All Hospital Maintenance Staff in serviced to "Securing Gas Cylinders" maintenance department policy on July 16, 2012 Responsibility:Jody Fox, Director of Plant Operations.Date of completion:July 16, 2012 Exhibits include: A. blank copy of Safety Hazards Inspection B. Completed example of Safety Hazards Inspection C. Copy of Maintenance Department In Service of "Hospital Regulation 40-6 Gas Cylinders" and "Maintenance Department Securing Gas Cylinders"Tag S1118 #2 a&b - Expiration Date of Sterile Supplies **Plan of**	07/16/2012

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	was 1 fire extinguisher on the floor unsecured by chain or holder. 3. If the above extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.1. Facility policy " Expiration Date On Sterile Supplies " , last reviewed/revised July 2011, page 1, "All sterile supplies distributed to the nursing departments are checked for expiration dates by the Materials Management personnel prior to distribution". 2. During tour of Medical/Surgical unit on 6-25-2012 at 11:00 am the following was noted: a. 2 packages of suture in the stock area which contained expiration dates of 01/2011. b. 7 cans of Isosource HN 250 mL, expiration date 12/2009. c. an Olympic blanket warmer "Warmette" containing blankets for patient use which lacked a thermometer and was set at 150 degrees F., measured 135 degrees F. inside by a facility maintenance person, and contained a manufacturer's warning box on the side of unit indicating that internal temperature should not exceed 120		**Correction**: 7/1/12: Monthly supply check completed for outdates for ICCU Department. 7/19/12: Staff memo placed in units and in unit communication books re: monthly checks for outdated supplies. Unit secretary assigned to check supplies for outdates every month and document completion on monitor checklist. Unit managers will audit checklist each month for compliance. 7/31/12: Staff meeting to address responsibility for monthly supply outdate checks. **Prevention:** Continued monitoring and audit of monthly supply outdate compliance. **Responsibility:** Unit secretary to complete monthly review of supplies for outdates. Denise Stepro, RN and Kammie Meek, RN, ICU/Med-Surg Nursing Managers are responsible for compliance audit and reporting quality assurance monitors to the Department of Medicine quarterly. **Date of Completion:** 7/1/2012: Supply outdates checked for month of July. Ongoing monthly responsibility. **Exhibits:** 1. Memo dated 7/19/2012 2. ICCU Monitor checklist – July 2012 3. Med-Surg Monitor checklist – July 2012 Tag S1118 #2 (c) Blanket Warmer **Plan of Correction:** · 7/5/12: Internal thermometer received and placed inside blanket warmer for internal temperature monitoring. · 7/19/12: Memo placed on unit and in communication book	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151333	A. BUILDING 00 B. WING	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	degrees F. 3. During interview with S2 on 6-27-2012 at 9:45 AM, S2: a. verified the above findings. b. indicated that the blanket warmer should have had a thermometer in it to monitor the temperature of the blankets and that the facility should follow the manufacturers warning labels for the Olympic blanket warmer. c. indicated it is the nursing staff's responsibility to check unit items periodically for outdates whether sterile items or nutritional items, to remove expired items from service, and to assure that blankets are kept at a temperature not to exceed that recommended by the manufacturer.		reminding staff about monitoring of blanket warmer to assure that blanket temperatures do not exceed manufacturer's recommendations. · 7/31/12. Staff meeting to discuss delegation of monitoring duties and expectations of staff to meet compliance. Introduction of new monitoring forms with follow up maintenance log. **Prevention:** The Charge Nurse will assign daily monitoring responsibilities to staff. If duty not completed by end of shift, the Charge Nurse will be responsible for completing the assignment and reporting non-compliance to unit managers. Nursing Managers will complete random compliance audit of monitor checklist. **Responsibility:** Charge Nurse is responsible for daily compliance. Denise Stepro, RN and Kammie Meek, RN, ICCU/Med-Surg Nursing Managers are responsible for compliance audit. **Date of completion:** 7/5/2012: Thermometer placed inside blanket warmer to verify internal blanket temperature. **Exhibits:** 1. Blanket Warmer Monitor Checklist – July 2012. 2. Memo dated 7/19/12. 3. charge nurse duties, crash cart checklist 4. New Monitoring Forms: A. Equipment monitor checklist B. Equipment Log Maintenance Sheet	