| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| S 0000<br><br>Bldg. 00 | This visit was for a standard licensure survey.<br><br>Facility Number: 005077<br><br>Survey Date: 05-31-2016 - 06-02-2016<br><br>QA: 7/7/16 jlh | S 0000 | | |
| S 0270<br><br>Bldg. 00 | 410 IAC 15-1.4-1<br>GOVERNING BOARD<br>410 IAC 15-1.4-1(a)(6)<br><br>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:<br><br>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.<br>Based on document review and interview, the governing board failed to review reports of quality activities for 1 contracted service as part of its comprehensive quality assessment and performance improvement (QAPI) program.<br><br>Findings include: | S 0270 | The deficiency was corrected by the Director of Quality/Risk Management.<br>Therapy Pets of Greater Cincinnati was added to the Contract Services Section of Quality Assurance Year 2016 worksheet. Therapy Pets of Greater Cincinnati and all other contract service performance will be documented and submitted to | 08/01/2016 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | 1. Review of the governing board minutes for calendar year 2015, indicated they did not include review of reports for the contracted service of animal therapy.<br><br>2. Interview of employee #A3, Director Quality/Risk Management, on 06-02-2016 at 10:50 am, confirmed the above and no further documentation was provided prior to exit. | | the governing board in November 2016, as stated in the Dearborn County Hospital IOP Plan dated January 2016. | |
| S 0330<br><br>Bldg. 00 | 410 IAC 15-1.4-1<br>GOVERNING BOARD<br>410 IAC 15-1.4-1(c)(6)(K)<br><br>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:<br>(6) Require that the chief executive officer develops policies and programs for the following:<br><br>(K) Maintaining personnel records for 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.<br>Based on document review and interview, the facility failed to conduct a post offer physical according to facility policy for 3 of 4 contracted employees, | S 0330 | The deficiency will be corrected by the Director of Occupational Health and the Occupational Health Registered Nurse with the following actions: | 08/15/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | and failed to follow facility policy for a known positive tuberculosis skin test employee in 1 of 11 employee health files reviewed.<br><br>Findings include:<br><br>1. Review of facility policy **OCCUPATIONAL HEALTH POLICY & PROCEDURE OH501**, Revised Date: 7/15, indicated "... Occupational Health Department **USING THE FOLLOWING FORMS:** Pre-Employment/Post Offer History and Physical for all Employees ... On day of physical: ... review physical requirement forms."<br><br>2. Review of 4 contracted employee health files indicated files N9 and N10, contracted nurses, and file #P1, contracted housekeeping director, lacked documentation of a physical requirement form.<br><br>3. In interview, staff #60, Director of Occupational Health and Education, 06-01-16 at 1447 hours confirmed the lack of a physical requirement form for contracted nurses N9 and N10, and no other documentation was provided prior to exit.<br><br>4. In interview, on 06-02-2016 at 11:25 | | 1.The DCH TB form was revised on 07/27/16 to include a signature line indicating that the nurse/MA reviewed the annual questionnaire and a Chest Xray is ordered if any of the 5 questions answered were positive (Yes) for active TB symptoms. The new form became effective on 07/27/16. Chart audits will be conducted on all TB tests given during the month of August on August 31, 2016 for compliance of the new signature line.<br>2.File #9, speech therapist TB questionnaire was reviewed with staff member at time of state survey and she stated that she did not intend to answer Yes to any question and she was actually not “coughing up blood”. No further medical intervention was needed since she was negative for all symptoms of active TB.<br>3.Policy OH501 (Pre-employment/Post-offerProcedure) was revised on 07/27/16 to note that no physical is required for non-employed staff including contractors, students and temporary staff. The policy will be approved by the VP of Patient Care Services and the President & CEO; to be effective by 8/15/16.<br>4.Policy OH502 (New Employee Immunizations) was revised on 07/27/16 to clearly define employed vs non-employed (contactors, students, temporary) staff in regard to required | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | am, employee #A6, Director of Occupational Health and Education, confirmed the lack of a physical requirement form for contracted employee #P1, and no other documentation was provided prior to exit.<br><br>5. Review of a document entitled **OCCUPATIONAL HEALTH POLICY & PROCEDURE OH506, PROCEDURE FOR VOLUNTEERS, EMPLOYEES, CONTRACTED PHYSICIANS, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS FOR TB** [tuberculosis] **SCREENING,** Revised Date **10/15,** indicated "If someone is a known positive [tuberculosis], he/she will be asked and documented about symptoms of TB such as persistent cough, weight loss, loss of appetite, or night sweats. If the employee states he/she has these symptoms, a chest x-ray will be performed and the employees will be referred to his/her personal physician."<br><br>5. Review of 11 employee health files indicated file #P9, speech therapist, indicated on a document entitled **TB Screening Questionnaire/Annual Health Examination**, dated 03-25-2016, indicated employee #P9 had made the following entries: | | immunizations. The policy will be approved by the VP of Patient Care Services and the President & CEO; to be effective by 8/15/16.<br>5.Policy OH505 (Immunizations for Non-employed Staff) was revised on 07/27/16 to note the specific immunizations that are required but no physical is required for non-employed staff including contractors, students and temporary staff. The policy will be approved by the VP of Patient Care Services and the President & CEO; to be effective by 8/15/16.<br>6.Policy OH506 (TB Skin Test) was revised to not include non-employed staff in this policy but instead provide direction to Policy OH505 that is specific to non-employed staff including contractors,students and temporary staff. The policy will be approved by the VP of Patient Care Services and the President & CEO; to be effective by 8/15/16. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | **DO YOU HAVE (*CHECK ALL THAT APPLY*)**<br>checkmarked History of Positive TB Skin Test<br>checkmarked Year Converted (if know), indicated 2004<br><br>**HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST YEAR:**<br>3. coughing up blood? checkmarked Yes<br><br>6. Further review of the file of employee #P9 indicated there was no documentation of a chest x-ray having been performed and the employees having been referred to his/her personal physician.<br><br>7. In interview, on 06-023-2016 at 11:25 am, employee #A6 confirmed all the above regarding employee #P9 and no other documentation was provided prior to exit. | | | |
| S 0406<br><br>Bldg. 00 | 410 IAC 15-1.4-2<br>QUALITY ASSESSMENT AND IMPROVEMENT<br>410 IAC 15-1.4-2(a)(1)<br><br>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:<br><br>(1) All services, including services furnished by a contractor.<br>Based on document review and interview, the facility failed to have a monitor and standard for quality activities for 1 contracted service as part of its comprehensive quality assessment and performance improvement (QAPI) program.<br><br>Findings include:<br><br>1. Review of the facility ' s QAPI minutes and reports for calendar year 2015, indicated they did not include review of reports for the contracted service of animal therapy.<br><br>2. Interview of employee #A3, Director Quality/Risk Management, on 06-02-2016 at 10:50 am, confirmed the above and no further documentation was provided prior to exit. | S 0406 | The deficiency was corrected by the Director of Quality/Risk Management.<br>Therapy Pets of Greater Cincinnati was added to the Contract Services Section of Quality Assurance Year 2016 worksheet. Therapy Pets of Greater Cincinnati and all other contract service performance will be documented and submitted to the governing board in November 2016, as stated in the Dearborn County Hospital IOP Plan dated January 2016. | 08/01/2016 |
| S 0554<br><br>Bldg. 00 | 410 IAC 15-1.5-2<br>INFECTION CONTROL<br>410 IAC 15-1.5-2(a) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.<br>Based on document review and interview, the hospital failed to follow the manufacturer's instructions for testing the Cidex OPA Solution Test Strips when a new test strip bottle was opened in 1 instance.<br><br>Findings include:<br><br>1. Review of the manufacturer's recommendation for testing the Cidex OPA Solution Test Strips indicated "It is recommended that the testing of positive and negative controls be performed on each newly opened test strip bottle of CIDEX OPA Solution Test Strips."<br><br>2. On 05-31-2016 at 2:35 pm, review of 5 documents each entitled CIDEX OPA Solution Log Sheet, for the time period 01-29-2016 through 05-31-2016, indicated for each, entries titled:<br>QC Test Strips<br>QC Test Date<br>Tested By (Initials)<br><br>3. Review of all 5 Log Sheets indicated none of them had the above-stated entries completed. | S 0554 | The deficiency of lack of documentation of the QA done each time a new Cidex OPA Test-Strip bottle is opened was corrected by the Director of Imaging and staff of Ultrasound. An in-service for re-training of "Guidelines for Use of Cidex OPA" was completed on 7/7/16; on 7/8/16 the staff began recording the QA testing done on the QA/QML log when a new test-strip bottle is opened. The Ultrasound Technologist who opens the new bottle of test-strips is responsible for completing the testing and the documentation of this on the QA/QML log; this correction will be monitored from 8/1/16 through 10/31/16 for compliance; the Department Director of Imaging is responsible for this deficiency. | 07/08/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | 4. In interview, on the above date and time, an ultrasound staff employee confirmed the lack of entries and there was no other documentation of the testing of the strips according to the manufacturer's instructions when a new bottle was opened. No other documentation was presented prior to exit. | | | |
| S 0912<br><br>Bldg. 00 | 410 IAC 15-1.5-6<br>NURSING SERVICE<br>410 IAC 15-15-6 (a)(2)(B)(i)(ii)<br>(iii)(iv)(v)<br><br>(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:<br><br>(2) A nurse executive who is:<br>(B) responsible for the following:<br>(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.<br>(ii) Maintaining a current nursing service organization chart.<br>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.<br>(iv) Ensuring that all nursing personnel meet annual in-service | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | requirements as established by hospital and medical staff policy and procedure, and federal and state requirements.<br>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.<br>Based on document review, observation and interview the facility failed to ensure that nursing staff followed policy/ procedure as related to Point of Care bedside blood glucose testing.<br><br>Findings:<br><br>1. Review of policy/ procedure AA-3/POC-3, POINT OF CARE BEDSIDE BLOOD GLUCOSE TESTING last reviewed/revised 7/15, on page 1 indicated the following: ..... Follow manufactures guidelines regarding control solution stability.<br><br>2. Review of ACCU-CHEK Inform II manufacturer guidelines indicated the following: Note: Write the date the bottle was opened on the bottle label. The control solution is stable for 3 months from that date or until the "Use by" date on the bottle label, whichever comes first.<br><br>3. While on facility tour in the ICU, Intensive Care Unit, on 5-31-16 at 1310 | S 0912 | The deficiency will be corrected by the Accu-Check Inform II Nursing Point of Care Coordinator, Lab Point of Care Coordinator, and the Vice President of Patient Care Services. The (P&P) Policy/Procedure AA-3/POC-3 Point of Care Bedside Blood Glucose Testing states that Accu-Chek Inform II solutions will be labeled according to manufacturer's guidelines regarding control solution stability. This P&P is in draft form for amendment and states that control solution bottles must be labeled with the opening date and the discard date (3 months from the open date or until the "Use by" date on the bottle label, whichever comes first). By 8/5/16 all opened Accu-Chek Inform II solutions will have a label with both the opened date and discard date; a memo will be sent to all Nursing Staff, via email, reflecting the addition of the required "opening date". The monthly August Nursing Education Newsletter will provide education on the label changes as well. The Accu-Check Inform II Nursing Point of Care Coordinator will | 08/05/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | hours, it was observed that the glucometer high and low control solutions lacked an open date written on the label.<br><br>4. Interview with staff # 53, ICU manager, on 5-31-16 at 1333 hours confirmed the lack of an open dated written on the glucometer high and low control solutions labels. | | check compliance on 9/1/16 and 12/1/16. | |
| S 0952<br><br>Bldg. 00 | 410 IAC 15-1.5-6<br>NURSING SERVICE<br>410 IAC 15-1.5-6(d)<br><br>(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).<br>Based on policy/procedure review and record review the facility failed to follow the approved medical staff policy/procedure for the administration of blood for 5 of 7 transfusion records reviewed.<br><br>Findings included:<br><br>1. Review of "DHC BLOOD | S 0952 | The deficiency will be corrected by the clinical content coordinator. The Pre-Transfusion checklist will be updated to include a verification of "Baseline Vital Documented." Nursing staff will review the blood product administration policy FF-2. Education will be provided by the clinical content coordinator and unit manager via email notification and at unit meetings. Clinical content coordinator will be | 08/15/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | PRODUCT ADMINISTRATION, NURSING POLICY& PROCEDURE FF-2, Revised 9/15" indicated the following:<br>a. Steps 1.-6. followed by Step 7. which stated: " Obtain baseline vital signs and record in the electronic Transfusion Record..... "<br>b. Step 8. A.-F. followed by Step 8. G. which stated: "Retrieve blood from lab."<br>2. Review of seven transfusion records indicated the staff retrieved the blood from the lab without obtaining the baseline vital signs first, for 5 of the 7 transfusions reviewed: T#1, T#2, T#4, T#5, and T#6. T#5's record indicated the baseline vital signs were taken after the transfusion was started. | | responsible for plan of correction and will conduct 20 random blood transfusion chart audits for the month of September, October, and November. | |
| S 1118<br>Bldg. 00 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8 (b)(2)<br><br>(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:<br><br>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.<br>Based on document review and interview the facility failed to maintain an | S 1118 | The deficiency will be corrected by the Director of Patient Care Services. The unit clerks of each | 08/15/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | environment that is free from hazards to patients, public or employees as related monitoring of refrigerator temperatures.<br><br>Findings:<br><br>1. Review of policy\ procedure IC419, REFRIGERATOR/ FREEZER STORAGE last reviewed/revised 7/15, on page 1 indicated the following: Temperatures should be recorded at least twice daily with date, time and person recording the temperature. The desired temperature is located on the log.<br><br>2. Review of document REFRIGERATOR/ FREEZER TEMPERATURE LOG March 2016 ER, Emergency Room, Department indicated the following: March 11 lacked temperatures and staff completing the evening shift (PM) check, March 12 lacked temperatures and staff completing the PM check, March 25 lacked temperatures and staff completing the PM check, March 30 lacked temperatures and staff completing the PM check and March 31 lacked temperatures and staff completing the PM check.<br><br>3. Review of document REFRIGERATOR/ FREEZER TEMPERATURE LOG April 2016 ER Department indicated the following: | | unit will be designated responsible for recording the refrigerator temps twice daily for the nursing units. Education will be provided by the unit managers via email notification and at unit meetings. Unit managers of each unit will be responsible for the plan of correction and will review the temperature log weekly for the months of September, October, and November to monitor compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | April 22 lacked temperatures and person completing for the PM check, April 29 lacked temperatures and person completing the AM check and April 30 lacked temperatures and person completing the AM check.<br><br>4. Review of document REFRIGERATOR/ FREEZER TEMPERATURE LOG May 2016 ER Department indicated the following: May 1 lacked the person completing the PM check, May 6 lacked temperatures and person completing the PM check, May 9 lacked the person completing the AM check, May 15 lacked temperatures and person completing the PM check, May 18 lacked the temperatures and person completing the PM check, May 20 lacked temperatures and person completing the PM check, May 27 lacked the person completing the PM check and May 29 lacked the person completing the AM check.<br><br>5. Interview on 5-31-16 at 1210 hours with staff #53, Emergency Department manager, confirmed the findings on the March, April and May 2016 REFRIGERATOR/ FREEZER TEMPERATURE LOGS. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| S 1164<br><br>Bldg. 00 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8(d)(2)(B)<br><br>(d) The equipment requirements are as follows:<br>(2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:<br><br>(B) There shall be evidence of preventive maintenance on all equipment.<br>Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 5 of 5 pieces of equipment.<br><br>Findings include:<br><br>1. On 05-31-2016 at 1:30 pm, employee #A2, Maintenance Director, was requested to provide documentation of PM performed within the last year on a stair-step device and a Life exercise recumbent bike. Both items were located in the Physical Therapy area.<br><br>2. On 05-31-2016 at 1:45 pm, employee #A2 was requested to provide documentation of PM performed within the last year on a shoulder pulley device located in the Physical Therapy area.<br><br>3. On 05-31-2016 at 2:55 pm, employee | S 1164 | The deficiencies were corrected by the Director of Plant Operations & Safety as follows:<br>1. On 5/31/16, a workorder was issued (w/o #Y16002435) to inventory the stair-step devices used in Physical Therapy. After receiving the stair-step inventory, a checklist was developed and it was then added to the Maintenance Department's equipment inventory (STEPS-01) and Preventative Maintenance (PM) program. The PM will be completed "annually." The Life exercise recumbent bike has been removed from service.<br>2. On 6/1/16, a workorder was issued (w/o #Y16002438) to inventory the shoulder pulley devices used in Physical Therapy. After receiving the shoulder pulley inventory and locations, a checklist was developed and it was then added to the Maintenance Department's equipment inventory | 07/27/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | #A2 was requested to provide documentation of PM performed within the last year on a patient treatment recliner chair located in the Electroencephalography area.<br><br>4. On 05-31-2016 at 3:15 pm, employee #A2 was requested to provide documentation of PM performed within the last year on a pill packaging machine located in the Pharmacy department..<br><br>5. In interview on 06-02-2016 at 12:50 pm, employee #A2 indicated there was no documentation of PM performed within the last year on all the above-requested pieces of equipment and none was provided prior to exit. | | (PULLEY-01) and PM program. The PM will be completed "semi-annually." 3. On 6/1/16, a workorder was issued (w/o #Y16002437) to inventory the patient recliner chairs in Electroencephalography area and throughout the hospital. After receiving the patient treatment recliner chair inventory and locations, a checklist was developed and it was then added to the Maintenance Department's equipment inventory (CHAIR-01) and PM program. The PM will be completed "semi-annually." 4. On 7/27/16, a workorder was issued (w/o #Y16003314) to inventory the pill packaging machine (Auto Print Unit Dose System) in the Pharmacy Department; the PM will be completed "semi-annually." After receiving the information on the Auto Print Unit Dose system (pill packaging machine) located in the Pharmacy Department, a checklist was developed and it was then added to the Maintenance department's equipment inventory (PH-PILLPACK) and PM program. The Director of Plant Operations & Safety will remind Managers and Directors at Management Staff meetings the importance of informing the Maintenance/Biomed Department when they receive new equipment; also, managers will look for equipment when conducting monthly Safety | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | | | Environmental Surveys (SES). | |
| S 1166<br><br>Bldg. 00 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8(d)(2)(C)<br><br>(d) The equipment requirements are as follows:<br>(2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:<br><br>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.<br>Based on document review and interview, the hospital failed to document a current leakage check on 4 of 21 pieces of equipment.<br><br>Findings include:<br><br>1. On 05-31-2016 at 11:15 am, employee #A2, Maintenance Director, was requested to provide documentation of current electrical leakage checks for 21 pieces of equipment.<br><br>2. Review of documents indicated there was no documentation of current electrical leakage check for a CT scanner, Dishwasher (dietary), Gamma Camera, and Mammogram Scanner. | S 1166 | Dishwasher - A workorder was issued on 7/27/16 (w/o #Y16003318) to conduct an electrical leakage check on the dishwasher (dietary) The preventative maintenance (PM) checklist associated with this equipment was revised with instructions on conducting the electrical leakage check results and "pass or fail". The Director of Plant Operations will verify on the PM checklist that the electrical leakage is being checked and recorded. The Director of Plant Operations is responsible for this deficiency. The mammography, Gamma Camera, and CT Scan equipment are all serviced by General Electric (GE). They all had current electrical leakage checks done at installation, but this had not been part of the GE PM program. The Director of | 08/03/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150086 | A. BUILDING 00<br>B. WING | 06/02/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DEARBORN COUNTY HOSPITAL | 600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025 |

| (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 |
|---|---|---|---|---|
| | 3. Interview of employee #A2, on 06-01-2016 at 3:05 pm, confirmed there was no documentation for the above-four stated pieces of equipment and no documentation was provided prior to exit. | | Imaging contacted the Area Service Manager at GE who is scheduling these checks to be completed; he is also developing a plan, coordinating with GE corporate, to add these into the routine PM program. A process for completion was initiated on 7/27/16. Electrical check on CT Scan was done on 8/3/16 and will be monitored with each regularly scheduled PM. The Director of Imaging is responsible for this deficiency. | |