

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/20/2011
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005064</p> <p>Dates: 9-19-11 through 9-20-11</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratory Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 09/28/11</p>	S000000	<p>10/12/11Ms. Hamel:Attached please find the Plan of Correction in response to Perry County Memorial Hosptial's 2011 state licensure survey. Please contact me at (812) 547-0285 or at <a href="mailto:scalvert@pchospital.org">scalvert@pchospital.org</a> for any questions you may have.SincerelySandy Calvert, RNQuality Management Director</p>	
S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice 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 governing board failed to ensure cardiopulmonary resuscitation (CPR) competence for 3 of 6 physicians (MD#1, 2, 5) and 1 of 5 allied health credentialed professionals (AH#2) who are privileged to provide direct patient care.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of credential files on 9-20-11 lacked evidence that 3 of 6 physicians (MD#1, 2, 5) and 1 of 5 allied health credentialed professionals (AH#2), privileged to provide direct patient care, had documentation of current competency in CPR.</li> <li>Review of the Medical Staff Bylaws/Rules and Regulations on 9-20-11 lacked documentation that CPR competency requirements were addressed for medical staff and allied health</li> </ol>	S000318	1, 2 & 3.) Cardiopulmonary resuscitation (CPR) competency requirements for physicians and allied health credentialed professionals will be addressed during the October 18, 2011 Medical Executive Committee. (See Attachment A: agenda and checklist). Suggested revisions to the Medical Staff Bylaws/Rules and Regulations made by the Medical Executive Committee will be forwarded to the November 8, 2011 Medical Staff Meeting for a 1st reading.ADDENDUM SUBMITTED 10/24/11The Medical Staff Credentialed will monitor Allied Health Professionals/MS credential files for current CPR competency and report results to the Credentials Committee (MEC) annually.	11/08/2011			

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S000556	<p>professionals privileged to provide direct patient care.</p> <p>3. Interview with B#9 on 9-20-11 at 0930 hours confirmed the credential files of 3 of 6 physicians (MD#1, 2,5) and 1 of 5 allied health credentialed professionals (AH#2), privileged to provide direct patient care, lacked documentation of current competency in CPR; B#9 confirmed the Medical Staff Bylaws/Rules and Regulations do not address CPR competency requirements for medical staff and allied health professionals privileged to provide direct patient care.</p> <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 upon personnel record reviews, the facility failed to document sufficient information to attest that the TB results for five of ten employees had been</p>	S000556	1.) The Infection Control policy 'Employee Tuberculosis Monitoring' #26.6 (See Attachment B) was revised to state the tuberculin test will be	10/18/2011

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S000871	<p>correctly interpreted.</p> <p>Finding(s) included:</p> <p>1. On 9/20/11 at 11:00 a.m., review of five personnel TB records (#s K1, 2, 3, 5 and 12) failed to indicate complete documentation to ascertain that each employee's TB record had been 1) read no earlier than 48 hours or 2) later than 72 hours. There was no documentation indicating when their initial inoculations were performed or when their inoculations were read and documented.</p> <p>410 IAC 15-1.5-5 Medical Staff 410 IAC 15-1.5-5(b)(3)(O)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(3) include, but not be limited to, the following:</p> <p>(O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual</p>		<p>dated and timed when given and read. This policy will be taken to the Infection Control Committee meeting on October 18, 2011 for approval and then placed on the hospital intranet for reference. The form to record the TB tests has been revised to include the time given and read (See Attachment C). An email to alert staff to the timing of TB tests was sent to nurse managers on 9/21/11 and posted in departments (See Attachment D). It will also be reviewed at appropriate monthly staff meetings by the specific department manager. ADDENDUM SUBMITTED 10/24/11 The Infection Control practitioner will monitor dating and timing of tuberculin tests quarterly and report results to the Infection Control Committee and the Quality Improvement Sub-Committee quarterly.</p>				

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	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>Based on document review, closed medical record review and interview, the facility failed to ensure that verbal orders were authenticated by the responsible individual within 24 hours as required by facility policy in 2 of 30 medical records reviewed.</p> <p>Findings included:</p> <p>1. Facility policy "Verbal Orders Acceptance, Transcription and</p>	S000871	1 & 2. A & B). Health Information policy 'Medical Records Completion' (See Attachment E) will be reviewed with all nurse managers at the 10/6/11 Nursing Cabinet meeting by the Assistant Director of Nursing (See Attachment F). The policy will also be reviewed with all staff nurses during staff meetings on 10/13/11 by the Med Surg Nurse Manager (See Attachment G). Policy was also reviewed in the Health Informations staff meeting on 10/3/11 by HIM	10/13/2011	

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	<p>Implementation" last reviewed/revised 6/2011 states on page 2 that during daily order review, if the time from acceptance of the verbal order by staff has exceeded 24 hours without countersignature from the physician, that individual will contact the physician and request signature.</p> <p>2. Review of closed medical records on 9/20/2011 at 11:00 AM indicated patient: A. N2 had a telephone order dated 8/19/2011.     i. N2 was discharged on 8/19/2011.     ii. The order lacked a countersignature. B. N14 had a telephone order dated 7/27/2011.     i. N14 was discharged on 7/27/2011.     ii. The order lacked a countersignature.</p> <p>3. During interview on 9/20/2011 with S1 at 11:45 AM, S1 confirmed the above.</p>		<p>Director.ADDENDUM SUBMITTED 10/24/11Monitoring for counter signature of verbal orders within time frame as outlined by policy will be done on 30 charts per month and reported to the Medical Staff Peer Review Committee quarterly by the HIM Director.</p>		

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S000872	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(P)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on document review, closed medical record review, and interview, the medical staff failed to complete the medical record within thirty (30) days of discharge in 7 of 30 medical records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of Health Information Management policy "Medical Record Completion Policy", last reviewed/revised January 2011, indicated on page 2, 5(c) "General Requirements" "The final diagnosis will be documented along with completion of the medical record within thirty (30) days following discharge".</li> <li>2. Review of closed medical records on 9/20/2011 at 11:00 AM indicated patient:</li> </ol>	S000872	10/1/11 and ongoing.1 & 2. A, B, C, D, E.) A memo was sent to all physicians on 10/3/11 (See Attachment H) with Health Information policy 'Medical Records Completion' attached (See Attachment E). HIM staff will review records for completion in stated time frames per policy. HIM Director will monitor and report results via the 'Ongoing Medical Record Review' to the Medical Staff Peer Review Committee quarterly, effective 10/1/11. (See Attachment I).A special department meeting to reiterate the need to make sure all charts have all necessary signatures before filing and within appropriate time frames was held 10/3/11. (See Attachment J). HIM Director will monitor with 'Ongoing Record Review' by reviewing 30 charts/month and reporting quarterly to Medical Staff Peer Review Committee.The Medical	10/01/2011

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	<p>A. N1 was discharged 8/8/2011; consultation dated 8/4/2011 lacked authentication.</p> <p>B. N2 was discharged on 8/19/2011; history &amp; physical dated 8/17/2011 lacked authentication.</p> <p>C. N6 was discharged on 8/5/2011, discharge summary dated 8/2/2011 lacked authentication.</p> <p>D. N10 was discharged on 8/10/2011, history &amp; physical dated 8/10/2011 lacked authentication.</p> <p>E. N13 was discharged on 8/10/2011, history &amp; physical dated 8/4/2011 lacked authentication.</p> <p>3. Staff member S1 was interviewed on 9/20/2011 at 12:45 PM and indicated the above-referenced patient closed medical records had history and physicals, discharge summary or consultation report that were not completed within 30 days as required by facility policy.</p>		<p>Staff Coordinator will also add the 'Medical Records Completion' policy to the agenda for the Medical Staff meeting to be held 11/8/11.ADDENDUM SUBMITTED 10/24/11The HIM Director will be responsible for monitoring for completion of medical records by reviewing 30 charts per month and submitting results to the Medical Staff Peer Review Committee for review quarterly.</p>	

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6).</p> <p><b>Based on record/policy review and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for two of nine patients.</b></p> <p><b>Finding(s) include:</b></p> <p><b>1. The policy, "Blood and Blood Component Transfusion", approve 2/14/11, read: "The patient's full set of vitals are documented on the Blood Product Transfusion Form at the following intervals: approximately 1 hour after start of transfusion</b></p>	S000952	<p>10/13/11 and ongoing.1 &amp; 2). Re-education for staff involved with lack of documentation according to 'Blood and Blood Component Transfusion' occurred on 9/19/11 and 9/27/11 by the Evening Shift Supervisor and the Med Surg Nurse Manager. The above mentioned policy (See Attachment K) was reviewed in Nursing Cabinet on 10/6/11 (See Attachment F) with Nurse Managers by the Assistant Director of Nursing. The policy will also be reviewed with staff nurses at the 10/13/11 staff meetings by the Med Surg Nurse Manager (See Attachment G). The appropriate timing of transfusion vitals has been added to the competency checklist that is completed for every nurse during orientation and updated annually (See Attachment L). The annual education for all nurses will be added to the Health Stream Education (See Attachment M) by the Education</p>	10/13/2011			

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	<p><b>2. In review of nine patients receiving eighteen blood units, two of these received-units did not have complete documentation, per policy, on the Blood Product Transfusion Form including:</b></p> <p><b>Patient #4</b> --Unit #68 administered on 9/13/11 at 1930: The 3 hour vitals (to be taken each hour after the start time) were missing.</p> <p><b>Patient #9</b> --Unit #85 administered on 8/31/11 at 1745: The 1 hour vital (to be taken 1 hour after the start of the unit) was taken at 1900 in lieu of 1845.</p> <p><b>3. On 9/19/11 at 1:00 p.m., staff member # 8 acknowledged the above-listed patients had received blood without benefit of complete documentation, per policy, as required.</b></p>		Coordinator. It has also been added to the HMS Patient Care Care Plan/Worklist (See Attachment N). The Laboratory Director will continue to monitor blood tags for completion and report findings to Quality Improvement Sub Committee (QISC) quarterly. (See Attachment O).	

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S001024	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on policy review, observation and interview, the facility failed to ensure that the opening date had been documented for multi-dose medications as required by facility policy in 2 of 5 units toured.</p> <p>Findings included:</p> <p>1. Facility policy "Multiple Dose Vials" last reviewed/revised 2/8/2011 stated in pertinent part "All multi-dose vials shall be dated when opened. The expiration date of opened or entered multi-dose containers is 28 days, unless otherwise specified by the manufacturer. All insulins shall be discarded 28 days from</p>	S001024	<p>10/25/11 and ongoing.1, 2 &amp; 3.) The 'Multiple Dose Vial' policy will be revised by the Pharmacy Director to reflect changes requiring 'beyond use' dating rather than 'date opened' and presented to the Pharmacy and Therapeutics Committee for approval on 10/25/11. Following approval of policy, nursing education regarding revisions will occur via memo and at nursing staff meetings on 11/10/11 by Med Surg Nurse Manager. Pharmacy staff will continue monthly unit inspections to monitor for compliance. The Pharmacy Director will report findings of monthly inspections quarterly to the Quality</p>	10/25/2011

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	<p>initial vial entry. During the monthly expiration date checks and before each use, the opening date on multi-dose vials shall be checked and discarded if it exceed these dates".</p> <p>2. During tour of the facility on 9/19/2011 in the presence of S4 and S8, the following was observed:</p> <p>A. The medication refrigerator on the medical ward contained:</p> <p>i. Two (2) Novalog Insulin multi-dose (10 mL) vials which were opened and undated.</p> <p>ii. One (1) Novalin U100 Insulin multi-dose (10 mL) vial which was opened and undated.</p> <p>iii. One (1) Lantus U100 Insulin multi-dose (10 mL) vial which was opened and undated.</p> <p>B. The medication refrigerator on the Obstetrics/Nursery ward contained one (1) multi-dose vial (10 mL) of succinylchloride 200 mg which was opened and undated.</p> <p>3. During interview with S4, S4 indicated:</p> <p>A. Verification of the above.</p> <p>B. That the date the above vials were opened could not be determined; therefore, it also could not be determined that the drugs had not been open for more than 28 days.</p>		<p>Improvement Sub Committee (QISC). (See Attachment P).ADDENDUM SUBMITTED 10/24/11The Director of Pharmacy will be responsible for monthly unit inspections for compliance which will be reported to the Quality Improvement Sub Committee quarterly.</p>	

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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 interview, the facility created conditions which could result in hazards to staff or the public in 2 areas of the hospital.</p> <p>Findings include:</p> <p>1. While touring the hospital on 9-20-11 at 1210 hours in the presence of B#10, 4 unsecured fire extinguishers were observed on the floor in the generator room, which could result in a hazard to staff or the public if they were knocked over.</p>	S001118	<p>1). A Maintenance Work Request (See Attachment Q) has been completed by the Director of Plant Operations and a chain has been securely attached to the wall in the generator room to secure fire extinguishers when stored. All empty fire extinguishers were returned to the company on 10/5/11.2). A Maintenance Work Request (See Attachment R) has been completed to have an eye wash station installed. In-house maintenance staff will complete installation of eye wash station in area where water testing is done on 10/13/11.ADDENDUM SUBMITTED 10/24/11Monthly</p>	10/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2011
NAME OF PROVIDER OR SUPPLIER  PERRY COUNTY MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOSPITAL RD TELL CITY, IN 47586		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. While touring the hospital on 9-20-11 at 1225 hours in the presence of B#10, it was observed that the area where water testing is done using caustic chemicals, lacked an eye wash causing a hazard for staff or the public.</p> <p>3. Interviews with B#10 on 9-20-11 at 1210 hours and 1225 hours respectively confirmed the 4 unsecured fire extinguishers in the generator room and the lack of an eye wash in the area where water testing is done with the use of caustic chemicals could each result in a hazard to staff or the public.</p>		walk through/inspections of all fire extinguishers will be conducted by maintenance staff and reported quaterly to the Safety Committee and the Quality Improvement Sub Committee by the Director of Plant Operations.		