

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151315		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2012	
NAME OF PROVIDER OR SUPPLIER CAMERON MEMORIAL COMMUNITY HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 2/28/2012 through 3/1/2012</p> <p>Facility Number: 005037</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: cloughlin 03/09/12</p>	S0000	Cameron Memorial Community Hospital				

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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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and 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:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure 7 services provided by the hospital were part of its comprehensive quality assessment and improvement (QA&I) program: Bioengineering, Blood Bank, Laundry/Linen, Medical Records, Security, Transcription and Maintenance.</p> <p>Findings included:</p> <p>1. Cameron Memorial Community Hospital Quality Improvement Plan article IV states, "All service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program (HQR).</p> <p>2. The HQR meeting minutes were reviewed for 2011. The minutes did not</p>	S0406	<p>Components of this plan of correction have various completion dates, please see below. The Facilities Director will complete a draft report on the most recent annual Quality Assessment activities in Biomedical Engineering, Security, and Maintenance and turn into the Director of Performance Improvement by April 8, 2012. Responsible Party: Steve Wolfe, Facilities Director. The Housekeeping Coordinator will complete a draft report on the most recent annual Quality Assessment activities for the Laundry service and turn into the Director of Performance Improvement by April 8, 2012. Responsible Party: Seth Boszor, Housekeeping Coordinator. Facilities Director will finalize and forward the annual report for Biomedical</p>	04/08/2012			

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	<p>evidence that Bioengineering, Blood Bank, Laundry/Linen, Medical Records, Security, Transcription and Maintenance were being evaluated by HQR.</p> <p>3. The quality improvement program was reviewed with staff member #19 at 9:30 AM on 3/1/2012. Staff member #19 confirmed 7 hospital services: Bioengineering, Blood Bank, Laundry/Linen, Medical Records, Security, Transcription and Maintenance. were not reviewed in the HQR program.</p>		<p>Engineering, Security and Maintenance to Performance Improvement by May 1, 2012. Responsible Party: Steve Wolfe, Facilities Director. The Housekeeping Coordinator will finalize and forward the annual report for Laundry Services to Performance Improvement by May 1, 2012. The Director of Performance Improvement will present the completed reports for Biomedical Engineering, Security, Maintenance, and Laundry at the May 9, 2012 Hospital Quality Review committee meeting. Responsible Party: Patti Brown, Director of Performance Improvement. The Health Information Management Director provided a revised dashboard that included the Medical Records and Transcription Services Quality Assessment data on March 19, 2012. Responsible Party: Sandy Brady, Health Information Management Director. The Health Information Management Director will update the Medical Records and Transcription dashboard with 2nd quarter fiscal data by April 17, 2012. Responsible Party: Sandy Brady, Health Information Management Director. The Director of Performance Improvement will present the revised dashboard containing 1st and 2nd quarter fiscal data for Medical Records and Transcription at the May 9, 2012 Hospital Quality Review</p>		

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			committee meeting. Responsible Party: Patty Brown, Director of Performance Improvement. The Director of Performance Improvement has identified that the Blood Banking quality indicators "transfusion reactions" and "transfusion rates" are already being report to the HQR committee via the existing HQR dashboard. This was overlooked by the Director of Performance Improvement during the survey process.		

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S0556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to encompass all of the ongoing infection prevention activities into a written infection control program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the documentation of meeting minutes and ongoing infection prevention activities and surveillance with staff member #A5 at 12:45 PM on 02/28/12, the various components of an effective infection control program were in place. 2. When a copy of the facility's Infection Control Plan was requested, the document provided was a 2-page document titled "Infection Control Department Quality Review Plan", last revised 04/07. At 12:30 PM on 03/01/12, staff member #A5 confirmed the document specified how the program was monitored instead of 	S0556	<p>Components of this plan of correction have various completion dates, please see below. 1. The "Hospital-Wide Infection Control Plan" policy will be revised by Shannon King, Infection Prevention Coordinator, to encompass all aspects of an active, effective, and hospital-wide infection control/prevention program by April 1, 2012. This plan will include information regarding identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and healthcare workers. 2. Shannon King will email a draft of the revised policy to all Infection Prevention committee members for review by May 1, 2012. 3. The revised "Hospital-Wide Infection Control Plan" policy will be taken to the Infection Prevention committee meeting by Shannon King on May 15, 2012 for final review and approval, then annually</p>	04/01/2012			

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	exactly what the program entailed.		thereafter.		

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S0612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on observation, document review and staff interview, the facility failed to ensure that hot water was provided at the proper temperature for an effective means of destroying microorganisms while using the washer for the Sleep Lab's linen. Findings included: 1. Infection Control Department Quality Review Plan article III states, "Identification of Important Aspects of Services Delivered by the Infection Control Department: Prevent and control the spread of communicable/contagious diseases; Maintain a sanitary environment for patients, visitors, personnel, and the general public; Establish guidelines to follow in the implementation of Standard Precautions."</p>	S0612	<p>Components of this plan of correction have various completion dates, please see below. 1. The Infection Prevention Coordinator in coordination with the Infection Prevention Committee will maintain a sanitary environment for patients, visitors, and staff by enduring microbial destruction on all linens laundered within our facility through review and approval of the plan of correction for washing machine temperatures and times submitted by Steve Wolfe, Facilities Director. Shannon King, Infection Prevention Coordinator, will ensure the plan of correction meets CDC guidelines for microbial destruction by April 1, 2012. Deficiency correction includes installation of new</p>	04/01/2012			

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	<p>2. CDC guidelines for laundry services in health care facilities states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing."</p> <p>3. A memorandum dated 2/29/2012 from Whirlpool states, "The automatic temperature control electronically senses and maintains a uniform water temperature. Automatic temperature control regulates incoming hot and cold water. Automatic temperature control is automatically turned on when a cycle is selected. Sanitary cycle combines a super hot water temperature and fast-speed tumbling to help ensure the removal of heavy soils and stains. It is recommended that you set your hot water heater to 120 degrees F to ensure proper performance during this cycle. Only Sanitary cycle has been designed to meet the requirements of NSF Protocol P172 for Sanitizing Efficiency."</p> <p>4. At 2:15 PM on 2/28/2012, the Environmental Service Department was toured. The Department has a front loading Maytag washer and dryer for washing the bed linen for the 4 sleep lab rooms. The Maytag washer was observed having it's own water heater. The hot</p>		<p>equipment including temperature gauge, temperature probe and associated plumbing to verify appropriate (160 F) water temperature for effective destruction of microorganisms. Washer temperature monitoring will be recorded and logged periodically (once/weekly) during normal operations. The Housekeeping Coordinator will be responsible for corrective action and water temperature monitoring. This deficiency will be corrected by April 1, 2012. 2. Seth Boszor, Housekeeping Coordinator, will present the newly developed washing machine temperature QA tool to the Infection Prevention Coordinator by May 1, 2012 and report the QA monitor, including any necessary corrective action taken, to the Infection Prevention Committee on May 15, 2012 and at least quarterly thereafter.</p>				

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	<p>water line connected the the washer does not have a temperature dial nor the washer itself indicating the temperature of the water entering the washer. On the shelf located next to the washer was a container of 'KSS Enterprises Liquid Laundry Detergent'. The shelf had no powder nor liquid chlorine available for adding to the washer.</p> <p>5. At 11:45 AM on 2/29/2012, staff member #9 indicates the washer was utilized for washing the bed linen for the sleep lab. The linen was not sent to their contracted laundry service because bleach was used and the facility wants to make sure bleach was not used for cleaning the sleep lab's bedding because the threat of damaging the expensive bedding. The staff member indicated he/she contacted the manufacturer and they stated whatever the temperature of the water that enters the machine will maintain that temperature for 55 minutes due to the washer's internal sensing heater. The staff member confirmed he/she does not know what temperature actually enters the washer from the water heater and the facility has never looked into this process of using hot water instead of chlorine for their front loading washer.</p>						

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S0754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on medical record review, medical staff bylaws review, and interview, the facility failed to follow its own consent policy for 4 of 21 closed inpatient records reviewed (#N3, N6, N7, and N21).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The medical record for patient #N3, admitted 08/07/11, indicated a Consent and Authorization form signed on 08/09/11, the day of discharge. The medical record for patient #N6, admitted 12/16/11, indicated a Consent and Authorization form dated 12/22/11, with the notation, "Unable to get pt. sig. -Pt. expired 12/18/11." The medical record indicated the spouse and family members were at the bedside throughout the patient's hospital stay. 	S0754	<p>1. Re-educate the staff on the "Bylaws of the Medical Staff, VI. General Conduct of Care." Completed 03/14/2012. The preferred method of having the consents signed at the time of admission is to have the patient stop at the Registration Office to complete all paper work including the signing of the consent (which is part of the registration process).3. For the patients that do not stop at Registration, the following steps will be taken: a. During first shift Monday through Friday, a Registration Representative will go the floor to ensure all patients that have not stopped at Registration the day of admission, have consents signed and have such consents scanned into the inpatient account; and b. During second shift, third shift and all weekend shifts, after receiving the call from the floor that a patient has</p>	03/30/2012			

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	<p>3. The medical record for patient #N7, admitted 02/16/12, indicated a Consent and Authorization form dated 02/17/12, with the notation, "Pt. unable to sign per nurse, then expired, no POA avail." The medical record indicated the family members were at the bedside throughout the patient's hospital stay.</p> <p>4. The medical record for patient #N16, admitted 11/23/11, indicated a Consent and Authorization form dated 11/23/11, with the notation, "drop off from Lakeland." The medical record indicated the family members were with the patient.</p> <p>5. The facility's "Bylaws of the Medical Staff", last reviewed 11/11, indicated on page 5 under "VI. General Conduct of Care- a. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The nursing supervisor shall notify the attending practitioner whenever such consent has not been obtained. When so notified it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital."</p> <p>6. At 12:30 PM on 03/01/12, staff member #A26 confirmed the medical</p>		<p>arrived and needs to be registered, will ask the person calling to have the patient sign a consent and fax the consent down to Registration. The Registration Representative will follow up at the end of each of their respective shifts to ensure that all inpatient registrations during their shift have a signed consent for the day of admission. These consents will be scanned into the patient's inpatient account. Patient Access Supervisor will meet with the nursing leadership to coordinate and train the staff on the new process. Will be completed by 03/30/2012. A Registration Policy and Procedure will be developed to include the information in 2 and 3 above. Will be completed by 03/30/2012 and monitored monthly for compliance by Responsible Party, Marcia Jackson, Patient Access Supervisor.</p>				

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	record findings and indicated there was no other consent policy. He/she indicated the requirement for obtaining the consents was not followed.			

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S0871	<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 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>						

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	<p>Based on medical record review, policy and procedure review, and interview, the facility failed to ensure the staff documented "read back and verified (RB&V)" for physician orders that were obtained verbally or by telephone for 4 of 21 closed in-patient records reviewed (#N5, N6, N7, and N21).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The medical record for patient #N5 indicated physician orders received verbally by the nurse on 11/21/11 and via the telephone on 11/20/11, but lacked documentation of "read back and verified" or RB&V. The medical record for patient #N6 indicated physician orders received by the nurse on 12/16/11, but verbal or telephone order was not documented, and verbal orders received on 12/17/11, but neither order had documentation of "read back and verified" or RB&V. The medical record for patient #N7 indicated orders written by the nurse as received from the physician on 02/16/12, but verbal or telephone order was not documented, nor was "read back and verified" or RB&V documented. The medical record for patient #N21 	S0871	<p>Components of this plan of correction have various completion dates, please see below. 1. The hospital's read back and verify (RB&V) policy will be reviewed at the next nurses meeting by the Inpatient Team Leader on March 21, 2012 for Med-Surg and by the OB Clinical Coordinator on April 11, 2012 for OB Department. 2. The Inpatient Team Leader will also post a memo in the Med-Surg communication book for staff nurses by April 1, 2012 reviewing the RB&V policy. OB Clinical Coordinator will email OB staff a memo by April 1, 2012 reviewing the RB&V policy. 3. QA monitors will be completed monthly by Inpatient Team Leader (for Med-Surg) and by the OB Clinical Coordinator (for OB) regarding the completeness of the RB&V policy. This will be initiated with the month of March 2012 and completed monthly for one year. Results will be reported quarterly by June 30, 2012 by the Inpatient Team Leader at the Med-Surg nurses meeting and by the OB Clinical Coordinator at the OB nurses meeting. 4. Individual counseling/coaching will be conducted by Inpatient Team Leader (Med-Surg) and OB Clinical Coordinator (OB) as indicated.</p>	04/01/2012			

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	<p>indicated physician orders received verbally by the nurse on 01/01/12, but lacked documentation of "read back and verified" or RB&V.</p> <p>5. The facility policy titled "Verbal/Phone Orders and Read Back", last reviewed March 2011, indicated, "...5. When accepting a telephone or verbal order, the order will be written and then read back and verified to the person giving the order to assure that the order has been received correctly. The read back and verification must be documented after the signature of the person accepting the order. ...6. The person who receives the verbal/telephone order will write on the physician's order sheet (in the appropriate columns) the date and time the order was received, the name of the physician, the name and credentials of the person giving the order if this person is not a physician, sign the order with his/her first initial, last name, and credentials and designate 'RB&V' for read back and verification."</p> <p>6. At 12:30 PM on 03/01/12, staff member #A26 confirmed the medical record findings and indicated those particular orders should have had the notation of RB&V written after them.</p>						

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S1014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on observation, policy and procedure review, and interview, the facility failed to ensure its medication policy was followed in the surgical area.</p> <p>Findings included:</p> <p>1. Upon entering the pre-op area at 11:20 AM on 02/28/12, accompanied by staff member #A15, 2 medications, Pepcid and Cefzolin, were observed on the counter beside the cart/bed with other supplies in preparation for the admission of a patient. The room was absent of patients or staff.</p> <p>2. The facility policy titled "Medication Management- Storage", last revised 12/2011, indicated on page 2, "...All drugs removed from a medication storage area must be removed just prior to administration and only for one patient at a time. Once removed, the drug must remain with the individual at all times and may not be left unattended."</p>	S1014	<p>Components of this plan of correction have various completion dates, please see below.1. Review Policy for Medication Management-Storage-Storage: General, 09-01 with Operating Room and Pre-Op staff during staff update 03/12/2012. Copy of policy filed with minutes.</p> <p>2. Implementation of a Random Observation of Medication Storage by Operating Room Director and/or Coordinators. Documentation will include a log sheet with corrective actions. Completion date: 03/19/2012.3. Operating Room Director and Coordinators will be directly responsible for ensuring corrective actions are initiated. Completion date: 03/19/2012.4. Medication Safety Toolkit will be implemented as a yearly competency for all staff involved in administering or handling of medication. Completion date: 06/01/2012.</p>	03/19/2012			

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	<p>3. At 11:25 AM on 02/28/12, staff member #15 indicated the patient should arrive within a few minutes because the surgery was scheduled for 1:30 PM.</p> <p>4. At 1:00 PM on 03/01/12, staff member #15 indicated when he/she checked into the situation, it was determined that the nurse was called away to assist another nurse. Staff member #15 indicated this was not an acceptable or normal practice.</p>			

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S1118	<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, document review, and staff interview, the facility failed to ensure the Biohazard room's Hand washing sink/eye washing station were not obstructed for easy accessibility and failed to ensure hospital staff utilize personnel protective equipment (PPE) for chemical Cidex OPA in the Imaging Department and failed to ensure the safety of staff and patients in the obstetrical (OB) and emergency (ED) departments of the hospital.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 2/28/2012, the Biohazard Room was inspected. The handwashing sink and the eye-washing station plumed to the handwashing sink were covered in empty folded biohazard cardboard storage boxes that prevented easy accessibility.</p>	S1118	<p>Components of this plan of correction have various completion dates, please see below. Item #1The deficiencies observed in the biohazard room were corrected by rearranging the packaging materials so as to provide unhampered and easy access to hand washing sink and eye-washing station. Proper placement and the need for continual access to the area were addressed with the Housekeeping staff that is responsible for the placement and use of the packaging materials. This communication was presented via department shift meetings on 03/01/2012 and 03/02/2012. The Housekeeping Coordinator will continue to monitor the organization of materials in that area. The deficiency was corrected March 1, 2012. Item #2,3,4,5,6,7&91. All chemical disinfectants located in Radiology, OB, ED and Med-Surg</p>	04/01/2012			

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	<p>2. The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for semi-critical devices, in the Imaging Department for the Ultrasound. Cidex OPA manufacture sheet requires use PPE when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns.</p> <p>3. At 2:45 PM on 2/28/2012, the ultrasound room in the Imaging Department was inspected. The ultrasound room contained Cidex OPA and there was no PPE available within the room.</p> <p>4. At 2:50 PM on 2/28/2012, staff member #11 indicated he/she does not wear personal protective equipment when handling the high-level disinfectant.</p> <p>5. During the tour of the OB department at 10:00 AM on 02/29/12, accompanied by staff members #A7 and A28, the following observations were made: A. A refrigerator, with a biohazard label, in the clean storage room containing a syringe of whitish/yellow fluid which was labeled with a patient's name and the date, 01/26/12. The refrigerator did not have any documentation of temperature checks. B. An instrument enzymatic cleaner, Prolystica 2x Concentrate, in the soiled utility room with gloves as the only personal protective equipment (PPE).</p>		<p>were inventoried by Infection Prevention Nurse, Housekeeping Coordinator and the Safety Officer on March 16, 2012.2. Chemical Disinfectant Reference List was developed and approved by Infection Prevention Nurse, Housekeeping Coordinator and Safety Officer on March 20, 2012. The list includes disinfectant name, intended use, proper reconstitution/storage, appropriate personal protective equipment (P.P.E.) to be worn during utilization of each product, and kill time, etc.3. Chemical Disinfectant Reference List will be posted in ED, Med-Surg, OB soiled utility rooms and appropriate location in Radiology Department by Housekeeping Coordinator by March 26, 2012.4.a. Nurses and nurse techs will be education on proper use of disinfectants by Director of Nursing on March 21, 2012. b. Imaging Staff will be educated on proper use of disinfectants by Radiology Director by March 30, 2012.5. ED, Med-Surg, OB Unit Managers and Radiology Director will ensure the proper use and availability of P.P.E in each of the soiled utility rooms and appropriate location in the Imaging Department by April 1, 2012.6.a. IP Resource Nurse & Outpatient Resource Nurse will conduct monthly QA audit of appropriate use and availability of P.P.E. in ED, Med-Surg and OB soiled utility rooms by April 30,</p>				

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	<p>6. During the tour of the ED at 9:30 AM on 03/01/12, accompanied by staff members #A24 and A25, several chemicals, Metricide OPA, Prolystica 2x Concentrate, and Hyperfect, were observed for use in the soiled utility room. Gloves were the only PPE observed in the room.</p> <p>7. Manufacturer's literature for the Prolystica enzymatic cleaner indicated gloves and eyewear should be worn when using the chemical. Manufacturer's literature for the Metricide OPA indicated gloves, eyewear, and aprons should be worn when using the chemical.</p> <p>8. At 10:30 AM on 02/29/12, staff member #A28 indicated the refrigerator with the biohazard label on the OB unit was used for breastmilk, but was used infrequently and was not monitored by the nursing staff. He/she indicated there were no patients on the OB unit at this time and the syringe of fluid in the refrigerator should have been discarded.</p> <p>9. At 9:45 AM on 03/01/12, staff member #A25, who used the chemicals in the ED, indicated he/she only wore gloves when using the various chemicals.</p> <p>10. At 11:30 AM on 03/01/12, staff member #A5, indicated the refrigerator for the breastmilk was apparently missed when all of the hospital refrigerators were placed on a daily monitoring schedule.</p>		<p>2012 and report deficiencies to unit managers for action as needed. QA audit will continue monthly for one year. b. Radiology Director will conduct month QA audit of appropriate use and availability in the Imaging Department beginning by April 30, 2012 and will take the necessary actions for any deficiencies for Imaging Department. QA audit will continue monthly for one year. Item #81. Syringe of breast milk found in OB freezer was discarded by OB Clinical Coordinator during ISDH survey on March 1, 2012.2. OB Clinical Coordinator will inspect freezer monthly and discard any breast milk syringes left by discharged patients. Item #5.A./8./10.1. The upright freezer located in the OB clean storage room was added to the annual "Refrigerator/Freezer Inventory Log" for temperature monitoring. This freezer with the biohazard label has also been labeled with a "Staff Use Only" sticker. It has also been defrosted, cleaned, and has a new control dial as of 03/07/2012.2. By April 1, 2012 a section specific to the breast milk freezer will be added to the "Refrigerator/Freezer Temperature Monitoring" policy by Shannon King, Infection Prevention Coordinator, reflecting current CDC guidelines and labeling with review and approval by Infection Prevention Committee members who sign</p>				

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			<p>this policy which include the Facilities Director, Pharmacy Director, Food Services Director, Housekeeping Coordinator, Director of Nursing and the Laboratory Team Leader representing the Laboratory Department. 3. A temperature monitoring log and troubleshooting log specific to the breast milk freezer and its require temperatures was developed by Shannon King, Infection Prevention Coordinator, on March 16, 2012.4. Daily temperatures will be monitored by Robert Wheaton in the Facilities department beginning no later that April 1, 2012.</p>		

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and staff interview, the facility failed to ensure the hospital's Maytag washer and floor scrubbers are given preventive maintenance.</p> <p>Findings included:</p> <p>1. Cameron Memorial Community Hospital Medical Equipment Management Plan article III section D states, "Planned and Preventive Maintenance (PM) are scheduled primarily on an interval-based schedule. Strategies used to set these intervals are based upon manufacturer's recommendation, organizational experience and/or statistical evaluations."</p> <p>2. The hospital has two types of floor scrubbers: Square Scrub, Speed Scrub 2001. The Square Scrub manufacturer's</p>	S1164	<p>Preventative maintenance schedules and logs will be developed, performed and maintained on floor scrubbers including the Square Scrub Machine and the Speed Scrub 2001 auto scrubber. This will also occur for the Housekeeping department's frontloading automatic washer. The schedule will be developed according to the manufacture's recommended maintenance schedule of weekly, monthly, quarterly, and annual recommendations. The Housekeeping Coordinator will complete the development of said preventive maintenance schedule log and assign the staff member responsible for completing above procedures by April 1, 2012.</p> <p>Addendum Floor scrubber(s) and washing machine equipment preventative maintenance will be documented monthly on Facilities Quality Monitor Tool and reported quarterly to HQR Committee.</p>	04/01/2012			

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	<p>maintenance schedule has daily, weekly, and annual preventive maintenance requirements. The annual requirement was to replace all isolators. The Speed Scrub 2001 manufacturer's preventive maintenance requirements include weekly, monthly, and quarterly checklist. The monthly preventive maintenance requirements include flush solution system, lubricate all linkage pivot points, and check machine for water leaks. The manufacturer's quarterly preventive maintenance requirements includes checking vacuum and brush motor for carbon brush wear; replace brushes when worn to a length of 10 mm or less.</p> <p>3. The Performance Series Front-loading automatic washer manufacturer's preventive maintenance requirements included inspecting the seal; check for wear and tear; and to operate a special cycle that uses higher water volumes and steam, in combination with AFFRESH washer cleaner or liquid chlorine bleach to thoroughly clean the inside of the washer.</p> <p>4. Staff member #9 provided P.M. Log Sheets on the two floor scrubbers. After review of the log sheets, the documentation was repairs the 2 machines have and the documentation did not provide evidence of the required</p>			

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	<p>preventive maintenance listed in the 2 manufacturer's manuals.</p> <p>5. At 10:00 AM on 3/1/2012, staff member #9 indicated the hospital washer has never had a preventive maintenance and the special cycle for internally cleaning the machine has never been done. The staff member confirmed the two types of floor scrubbers never had the required preventive maintenance listed in their manuals.</p>			

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, the facility failed to perform a "Shift/System Check" for 6 of 7 defibrillators accordance with manufacturer's recommendations: OB, PACU, TR1, TR2, ER, and MedSurg.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Hospital utilizes 1 type of defibrillator, Heartstart XL. The manufacturer recomends on every shift to perform a "Shift/System Check" every shift to verify that the Heartstart XL is functioning properly and to ensure that necessary supplies and accessories are present and ready to use. The OB Crashcart Inspection log noted the department has 3 shifts. The logs were reviewed on 3/1/2012 and the February 2012 inspection log was reviewed for the first 28 days. 19 shifts were not recorded on the log that the Shift/System Checks were performed. 	S1168	<p>Components of this plan of correction have various completion dates, please see below. PACU Defibrillator1. Review manufacture's recommendation for checking defibrillator every shift (for the Surgery Department that is equal to one shift a day when a patient is in the department) at Staff Update 03/12/12.2. Instructed staff to perform checks and turn Defibrillator Check Logs into Surgery Department Director or designee at the end of each month for review. OB, Trauma, ED, Med-Surg Defibrillator1. Staff will perform defibrillator system checks every shift including discharging the defibrillator recording on log. This procedure will be reviewed by Inpatient & Outpatient Team Leaders at the nurses meetings to be held on March 21, 2012. OB Clinical Director will also review the procedure at OB nurses meeting on April 11, 2012 and email the OB nurses by April 1, 2012. 2.a. The Inpatient Team Leader will</p>	04/01/2012	

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	<p>3. The PACU Crashcart Inspection log noted the department has 1 shift. The logs were reviewed on 3/1/2012 and the February 2012 inspection log was reviewed for the first 28 days. 6 active shifts were not recorded on the log that the Shift/System Checks were performed.</p> <p>4. The TR1 Crashcart Inspection log noted the department has 2 shifts. The logs were reviewed on 3/1/2012 and the February 2012 inspection log was reviewed for the first 28 days. One shift was not recorded on the log that the Shift/System Checks were performed.</p> <p>5. The TR2 Crashcart Inspection log noted the department has 2 shifts. The logs were reviewed on 3/1/2012 and the February 2012 inspection log was reviewed for the first 28 days. Two shifts were not recorded on the log that the Shift/System Checks were performed.</p> <p>6. The ER Crashcart Inspection log noted the department has 2 shifts. The logs were reviewed on 3/1/2012 and the February 2012 inspection log was reviewed for the first 28 days. Three shifts were not recorded on the log that the Shift/System Checks were performed.</p> <p>7. The MedSurg Crashcart Inspection log</p>		<p>assign Med-Surg nurse responsible for completing the above procedure each shift by April 1, 2012. b. The Outpatient Team Leader will assign ED nurse responsible for completing the above procedure each shift by April 1, 2012. c. The OB Clinical Coordinator will assign OB nurse responsible for completing the above procedure each shift by April 1, 2012.3. QA monitors will be conducted monthly for completeness of the defibrillator checks beginning the month of April 2012 and monthly thereafter. The Inpatient Team Leader will be responsible for initiating this for the Med-Surg unit. The Outpatient Team Leader will be responsible for initiating this for the ED. The OB Clinical Coordinator will be responsible for initiating this for the OB unit.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151315	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER CAMERON MEMORIAL COMMUNITY HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	noted the department has 3 shifts. The logs were reviewed on 3/1/2012 and the February 2012 inspection log was reviewed for the first 28 days. Two shifts were not recorded on the log that the Shift/System Checks were performed.			