

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150035	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/17/2011
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NAME OF PROVIDER OR SUPPLIER PORTER VALPARAISO HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 814 LAPORTE AVE VALPARAISO, IN46383
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005033</p> <p>Survey Date: 11/14-17/2011</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: cloughlin 12/05/11</p>	S0000		
S0178	<p>410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and staff interview,</p>	S0178	1. Administrative Assistant to CEO identified key contacts for	11/17/2011

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>the facility failed to post the hospital license in an area conspicuous and open to patients and the public in 2 of 2 instances.</p> <p>Findings:</p> <p>1. On November 16, 2011 at 9am, and in the presence of Employee #A10, at the Porter Sleep Disorders Institute offsite area of the facility, it was observed that there was no posting of the hospital license in this area.</p> <p>2. On November 16, 2011 at 10:15am, and in the presence of Employee #A10, at the Education &amp; Rehab Center offsite area of the facility, it was observed that the posted hospital license was dated "1999", thereby, out of date and not current.</p>		<p>each hospital location on 11-16-112. Copy of current license faxed to each site 3. Return e-mail received from each key contact confirming receipt and posting of current license.ONGOING COMPLIANCEAbove process will be utilized each time a new license is received.Chief Quality Officer will include on tracer checklist to verify with each tracer visit.</p>		

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S0362	<p>410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors.</p> <p>(B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement.</p> <p>(C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor.</p> <p>(D) Use discretion and sensitivity in contacts with potential organ donor families.</p> <p>(E) Notify the appropriate procurement organization of potential organ donors.</p> <p>(F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths.</p> <p>Findings:</p>	S0362	Action Plan1. Clinical Nurse Specialist responsible for IOPO program reviewed fall outs for the past 2 years and determined no pattern or trend by unit or shift. Completed review 12/12/11. 2. Plan developed by CNS and Nursing Administration to	12/16/2011	

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	<p>1. Review of the contract between the hospital and the Indiana Organ Procurement Organization, indicated the "Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died (including calling prior to the time Brain Death is declared), in the Hospital. "</p> <p>2. Review of the documentation presented failed to show all deaths were reported. Donation Activity Report for September 2010 indicated 22 deaths occurred and only 21 deaths were reported; October 2010 indicated 24 deaths occurred and only 23 deaths were reported; May 2011 indicated 29 deaths occurred and only 28 deaths were reported; August 2011 indicated 27 deaths occurred and only 26 deaths were reported.</p> <p>3. Employee #A18 was interviewed on November 15, 2011 at 12:45pm, at which time review of the IOPA contract documentation and the 2010 and 2011 reporting data verified the information.</p>		<p>strengthen current policy by assigning accountability and responsibility to Hospital Supervisor on each shift to ensure IOPO is notified of all deaths. Completed 12/16/11. Actions to Prevent Reoccurrence1. Raising awareness of all Nursing staff through education and designation of champions on each unit. 2. Establish a Doner Council with representation from nursing units and Hospital Supervisors to review ongoing audit compliance with requirements. 3. CNS will complete ongoing scorecard for IOPO and report to Quality Management Committee, Medical Executive Committee, and Board. Responsibility: Nursing Hospital Supervisor, CNS Coordinator responsible for IOPO</p>		

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S0594	<p>410 IAC 15-1.5-2(f)(3)(D)(ii)</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>(ii) Universal precautions, including infectious waste management.</p> <p>Based on observation, staff interview, and document review, the facility failed to ensure the Valparaiso Porter Hospital Laboratory Blood Bank had an accessible handwashing sink when needed and to meet the Universal Precaution requirements.</p> <p>Findings included:</p> <p>1. General Precaution 410 IAC 1-4-8 states, "All covered individuals and health care workers under this rule shall comply with the requirements imposed under the Indiana occupational safety and health administration's bloodborne pathogens standards (as found in 29 CFR 1910.1030). Hand hygiene shall be performed before and after touching a potential source, before a clean or aseptic</p>	S0594	<p>Corrective Action1. In consultation with Engineering, the department equipment layout was revised and the instrument that was draining in sink was moved to an alternate counter and a portable drain device that does not require sink access was installed. The original sink was converted back to a hand washing sink only. This was completed on 12/15/11 under the Direction of the Administrative Director of the Lab and the Director of Engineering.Future actions to prevent reoccurrence1. Equipment installation will include process and engineering review of regulatory requirements prior to installation of any new equipment. Responsible: The Administrative Director of Lab</p>	12/15/2011	

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	<p>procedure, after a risk of body fluid exposure, after contact with inanimate surfaces and objects in the immediate vicinity of a potential source, and after removing gloves."</p> <p>2. At 1:15 PM on 11/14/2011, the Blood Bank Department of Valparaiso Porter Hospital. The Blood Bank Department was self-contained room within the Laboratory Department. The sinks in the Blood Bank Department were observed stained and being used as utility sinks. Therefore, the Blood Bank room did not have an accessible hand washing sink.</p> <p>3. At 1:17 PM on 11/14/2011, staff member L9 indicated the Blood Bank Department does not have a designated handwashing sink. The staff member indicated the hand sink located in the Blood Draw room located across the hall would be used if hand washing was required. The staff member concluded and indicated the bathroom was located down the hallway if the Blood Draw room was occupied. The staff member confirmed a person from the Blood Bank would have to walk through two doorways to access a handwashing sink when needed.</p>				

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S0610	<p>410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation, staff interview and document review, the facility failed to ensure kitchen staff are washing hands as required by Retail Food Establishment Sanitation Requirements and hospital policies for Valparaiso Porter Hospital's Kitchen/cafeteria.</p> <p>Findings included:</p> <p>1. Retail Food Establishment Sanitation</p>	S0610	<p>Correction:1. The Department Director met with the Valparaiso staff on 11/21/11 and 11/22/11 and provided education and training regarding the required handwashing compliance. Staff was notified that they would be monitored for compliance and that their compliance was mandatory.2. On 11/29/11 the Department Director at the Valparaiso campus monitored the activity for handwashing and noted 100% compliance.3. On</p>	11/29/2011

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	<p>Requirements, 410 IAC 7-24-129, When to Wash Hands states, "Food employees shall clean their hands and exposed portions of their arms as specified under section 106 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: After touching bare human body parts other than clean hands and clean, exposed portions of arms; After using the toilet room; After caring for or handling service animals or aquatic animals as specified in section 116(b) of this rule; After coughing, sneezing, or using a handkerchief or disposable tissue; After drinking, other than as specified in section 113(b) of this rule, using tobacco, or eating; After handling soiled surfaces, equipment, or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with raw food and working with ready-to-eat food; Before touching food or food-contact surfaces; Before placing gloves on hands; and after engaging in other activities that contaminate the hands."</p> <p>2. Food and Nutrition Services Policy</p>		<p>11/29/11 the Chef at the Portage campus monitored the compliance with handwashing and the results indicated 100% compliance. 1. To ensue continuing compliance the staff will be observed for compliance on the monthly audit that is documented. In addition the management staff will observe and coach for handwashing when they are in the aeas daily. 2. Results will be reported to Infection Control Committee for accountabilityas a part of overall handwashing compliance for facility.Responsible: Director of Food and Nutrition</p>		

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	<p>8010:12.13, Handwashing states, "Proper hand washing technique is to be used by personnel. Hands should be washed: at the beginning of shift, before starting work; After using the bathroom; Before eating; Before and after each patient contact/between patients; Before putting on and after removing isolation attire; When removing gloves prior to putting on clean pair of gloves; and Before leaving work at completion of shift."</p> <p>3. The Porter Valparaiso campus kitchen was toured on 11/14/2011 at 11:25 AM. Several staff members were observed changing gloves without washing their hands between changing of the single-use gloves. The staff members working behind the room service deli station and the food service tray line were observed not washing their hands between changing of gloves. The staff member working on the room service deli station put his/her old gloves on the cutting board which was in direct contact with his/her cutting knife. Two chefs were observed changing their gloves multiple times without washing their hands between the changing of the single-use gloves. The staff member working on the room service fry station changed his/her gloves multiple times without washing hands between the changing of the single-use gloves. The staff member working in the cafeteria fry</p>			

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S1118	<p>station was observed changing gloves without washing hands between the changing of his/her single-use gloves.</p> <p>4 At 12:30 PM on 11/14/2011, staff member L7 indicated the issues of proper hand washing has been addressed several times with the staff. The staff member indicated he/she knows the lack of handwashing when changing gloves has been an ongoing issue and he/she confirmed the lack of proper handwashing during the inspection on 11/14/2011.</p> <p>5. At 4:30 PM on 11/14/2011 while touring Portage campus, staff member L2 indicated he/she also works at the Valparaiso campus and the hand washing practices have been addressed several times but it still continues.</p> <p>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 policy and procedure review,</p>	S1118	I. Chemical spills , histology	12/16/2011	

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	<p>document review, observation and staff interview, the facility failed to ensure the facility maintained a sanitary and safe environment for the Histology area located in Valparaiso Porter Hospital's Laboratory Department and Endolabs and Valparaiso Outpatient Campus (Chandana at Porter).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The Valparaiso Porter Hospital Fire Safety Management Plan #9590-05-01 states, "The Fire Safety Management Program is designed to assure an appropriate and effective response to fire emergency situations that could affect the safety of patients, staff, and visitors or the environment of Porter. The program is also designed to assure compliance with applicable codes and regulations."</li> <li>2. OSHA regulation 1910.106(e)(9)(i) for the handling of chemicals states, "General maintenance and operating practices shall be in accordance with established procedures which will tend to control leakage and prevent the accidental escape of flammable or combustible liquids. Spills shall be cleaned up promptly."</li> <li>3. At 1:20 PM on 11/14/2011, the histology area of Valparaiso Porter</li> </ol>		<p>section, fire proof flammable cabinet; Actions taken to correct: 1. Contents of the flammable cabinet were removed and the cabinet was cleaned on 12/15/112. The manufacturers product information was consulted to determine appropriate storage condition.3. The Eosin stain container is now stored in a container with an outer protective cover to prevent further leakage. Completed 12/15/11 To prevent reoccurrence, the Histology technicians were all educated during a department meeting on 12/13/11 about the standards and storage requirements. In addition the review of the cabinet is now included on the weekly safety audit as of 12/15/11. Responsible: Administrative Director of Laboratory and Histology Supervisor II. Endo Labs Eye wash station 1. The eye wash container for the unit was ordered and replaced by Engineering with a new unit that was full of the required amount of fluid on 12/17/11. A new lock was placed on the unit. 2. Unit added to Security checklist to check weekly on 12/1/11 by Security Director 2. Any breakage of seal or other deficiencies will be submitted to Engineering as an immediate priority for repair by Nursing Supervisor for Endo Labs. Action taken to prevent reoccurrence: 1. Weekly</p>				

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	<p>Hospital Laboratory was toured. The fire proof flammable cabinet was opened and discovered the shelf and the cabinet floor were coated with assorted chemical excess from the assorted chemicals stored in the cabinet. The filled cabinet of chemicals consisted of formaldehyde, 1% Eosin Alcohol, etc. The floor of the cabinet was observed with the surface heavily coated with a red chemical liquid. After further investigation, the excess was from a gallon container of 1% Eosin Alcohol. It was evident due to red liquid excess observed coated on the outer surface of the gallon container.</p> <p>4. At 1:25 PM on 11/14/2011, histology staff member L8 indicated the spill that was observed in the chemical cabinet was from the Eosin Alcohol.</p> <p>5. Policy No. EC.02.05.01.4.g, titled "Maintenance of Safety Showers and Eyewash Stations" reviewed at 2:00 PM on 11/16/11, indicated on pg. 1, under Procedure section, "Location of Equipment must be...less than 10 seconds travel time from the hazard, with no obstructions...Eyewash Stations...Operate underflow conditions on a weekly basis and record on log. Ensure that water is tepid (moderately warm), with no threat of scalding the eyes..."</p>		<p>monitoring of station by Security2. Reporting to Environment of Care Committee for accountability3. Replacement of eyewash station with a new thermostatically controlled eye wash station in the sterilization room which is the location of the hazardous material on 12/22/11.Responsible: Director of Security, Nursing Supervisor Endo Labs, Engineering DirectorIII. Valparaiso Outpatient Center Emergency Eye wash station not tested weekly and was blocked by numerous carts. Only connected to cold water. Action to Correct:1. Staff was educated about keeping eye was station clear of obstructions by Safety Director on 12/1/11. Monitoring with Environment of Care Rounding2. Security Department added eyewash station to their log for weekly testing as of 12/1/11 by Security Director. Also checking that area free of obstructions3. Work order submitted to replumb station to allow for mixing valve for tepid ranges to be completed by 12/21/11 by Engineering Director.Actions to Prevent reoccurrence: 1. Weekly monitory by Security Department2. Reporting to Environment of Care Committee for accountabilityResponsible: Director of Safety and Security, Executive Director of Outpatient Surgery Center, .</p>		

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	<p>6. Document titled "Fendall Pureflow 1000" for the emergency eyewash station at Endolabs, indicated "flow duration is 15 minutes..."</p> <p>7. While on tour of: A. Endolabs central sterilization area on 11/16/11 at approximately 10:10 AM, in the company of personnel P24 and P29, it was observed that the seal was broken on the emergency eye wash station. B. Valparaiso Outpatient Campus (Chandana at Portage) central sterilization/surgical areas on 11/16/11 at approximately 9:30 AM, in the company of personnel P24 and P25, it was observed that the emergency eye wash station had not been tested weekly according to policy and procedure. Also, in order to access the emergency eye wash station, personnel have to open the closed door from the central sterilization room and there were approximately 4 carts (crash cart, malignant hyperthermia cart, surgical cart, and miscellaneous cart) in this hallway directly outside of this door. Personnel then have to turn right and walk approximately 10 feet to the surgical scrub sinks located a little to the right of that.</p> <p>8. Personnel P29 was interviewed on 11/16/11 at approximately 10:30 AM, and confirmed the seal on the emergency eye</p>				

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	<p>wash station at Endolabs was broken and if it is opened all the way up, which it was done one time in the past, the fluid runs out. Therefore, it could not be determined if there was enough fluid in it to flow for 15 minutes per manufacturer's recommendations.</p> <p>9. Personnel P22 was interviewed on 11/17/11 at approximately 1:15 PM, and confirmed the emergency eye wash station at Valparaiso Outpatient Campus (Chandana at Portage) was located in an area with possible obstacles to personnel trying to gain access to it. It was also not tested weekly per facility policy and procedure and was hooked up to only cold water supply, not tepid as required per facility policy and procedure.</p>				