

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151326	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
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S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 01/25/2016 through 1/27/2016 Facility Number: 005055 QA: cjl 02/11/16	S 0000		
S 0584 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(3)(A) (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: (A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the hospital. Based on document review and interview, the infection control (IC) committee failed to ensure that all surgical patients were evaluated for surgical site infections by a qualified provider and reported and reviewed	S 0584	1. Collaborative meeting with Infection Control and Surgery Department on 2/16/16 in relation to SSI post op tracking. Process developed and approved by Administration that Surgery will submit to surgeons, our identified qualified providers, a listing of	03/01/2016

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>through the infection control program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The policy/procedure infection Control Program Plan (approved 1-15) indicated the following: "Monitor healthcare-associated infections and communicable diseases (see Appendix A, CDC Definitions) and report as indicated by policy or Indiana Law ...Surgical site infections." The IC plan failed to describe the process for assuring all surgical patients were monitored for surgical site infections by a qualified provider. 2. Review of the 2015 IC committee minutes dated 1-12-15, 3-12-15, 5-14-15, 7-9-15, 9-10-15 and 11-12-15 indicated that all surgical patients were mailed a questionnaire following their surgical procedure and indicated the monthly response rate was less than 60% returned. The IC minutes indicated there were no suspected or actual surgical site infections for the patients that returned the questionnaires. 3. During an interview on 1-26-16 at 1005 hours, the infection control nurse, staff A8, confirmed that the (4) surgeons providing surgical services at the facility were not receiving monthly listings of 		<p>surgical cases requesting feedback on any identified 30 day post SSI. Cases would exclude EGD's and colonoscopies. Revision to Infection Control Program Plan Appendix C - 2016 Surveillance Schedule completed 2/25/16 to include new survey process. New Surgery policy developed 2/26/16 outlining process for initiation and monitoring. Development of Infection Control Surgery 30 day Follow Up Report that will be submitted to qualified providers completed on 2/17/16. New policy, revised Appendix C, and 30 Day follow up form to be submitted with recommendations for approval to Infection Committee on 3/10/16. Educational letter notifying Surgeons of new process and scheduled start date will be sent 2/29/16. See Attachment 1-4: (Policy, 30 Day SSI Follow-up Report, Revised Appendix C, and Letter to Qualified Providers of new process) 2. Surgery will coordinate sending and receipt of the 30 Day SSI follow up report to each qualified provider. Information received will be reviewed, tallied, and submitted quarterly by Surgery to the Infection Control Committee. Cases identified real time with potential concerns of post op SSI will be submitted to Infection Control for further follow up. See attachment 5 (monitor log for Infection Control Committee). 3.</p>		

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S 0592 Bldg. 00	<p>their surgical patients from the IC committee staff to review and return after identifying any patients that may have experienced a surgical site infection. The IC nurse, staff A8, confirmed that the current surgical infection monitoring process failed to assure 100% of all surgical patients were monitored for surgical site infections.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(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>(i) Sanitation. Based on document review, observation and interview, the infection control committee (ICC) failed to maintain its policy/procedures for operating room (OR) cleaning and ensure that surgery cleaning and disinfecting was consistently provided to assure a safe and healthful surgical environment for</p>	S 0592	<p>Brenda Kelly, UHC Manager-Surgery Department4. 3/1/16</p> <p>1. Identified areas during survey process (Grills/Vents and Spiderweb) were cleaned at the time of the visit on 1/28/16. Supply and return air vents in Dirty Central were placed on a monthly PM that is completed by Housekeeping. Additional PMs were added to address the two return vents in each OR room</p>	02/18/2016

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	<p>patients and health care personnel.</p> <p>Findings include:</p> <p>1. The Association of periOperative Nurses (AORN) Recommended Practices for Environmental Cleaning (2015) indicated the following: "II.b.3 Damp dusting should be performed methodically, from top to bottom... II.c.5 Disinfectants should be applied and reapplied as needed, per manufacturers' instructions, for the dwell time indicated... III.b Cleaning of high-touch objects after each patient use should include cleaning of any soiled surface of the item and any frequently touched areas of the item (control panel, switches, knobs, work area, handles)... IV.e Sterile processing areas should be terminally cleaned ... sterile processing areas where decontamination occurs have some of the highest risks for environmental contamination of all perioperative areas... VI.b Cleaning and disinfection activities should be performed in a methodical pattern that limits the transmission of microorganisms. Cleaning an area in a methodical pattern establishes a routine for cleaning so that items are not missed during the cleaning process. The method for cleaning may ...reduce the risk of cross contamination of environmental surfaces. VI.b.1 Cleaning should progress</p>		<p>(1&2). Plant Operations will be responsible to maintain the monthly vent return cleaning in OR rooms 1& 2. Surgery Department policy SS.2400.046 – Cleaning (General) was revised on 2/18/16 to encompass the AORN recommended practices for environmental cleaning as well as including the exhaust vent cleaning schedule by Plant Operation. Site specific daily cleaning checklists were developed and implemented by Surgery, on 2/18/16, for each key area in the Surgery Department as well as an overall monthly cleaning checklist specific to walls and ceilings. These checklists will be presented at the next Infection Control Committee meeting on 3/10/16 with recommendation to approve. See Attachments 1-7 (After cleaning photos I, PMs for return air vents, PMs for OR Room vents, General Cleaning policy) 2. The added cleaning PMs for Housekeeping and Plant Operations will be monitored and tracked with expected compliance of 100%. Surgery maintains quality control items that are reported quarterly to Quality Management. Surgery will add reporting lines for each of the new daily and monthly cleaning checklists and document compliance for each of the defined areas. Expected compliance for this is 100%. The PM reporting as well as the</p>				

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	<p>from clean to dirty areas. VI.b.2 Cleaning should progress from top to bottom areas... VII.a.1 All high touch objects, in addition to objects cleaned as part of routine cleaning, should be cleaned and disinfected as part of enhanced [terminal] environmental cleaning ... IX.a.1 Policies and procedures... should include identification of responsible personnel [and] cleaning chemicals, materials, and equipment approved for use... X.a Process monitoring must be a part of every perioperative setting ...Process monitoring should include ...cleaning procedures [and] monitoring cleaning and disinfection practices."</p> <p>2. The surgery department policy/procedure Cleaning (General) (revised 5-15) failed to indicate the following:</p> <p>A. a methodical approach listing the flat surfaces and equipment from top to bottom</p> <p>B. the IC committee-approved disinfectants (including wet contact time) to be used for cleaning and disinfecting the surgical environment and OR suites</p> <p>C. a provision ensuring that all high-touch surfaces were cleaned and/or disinfected</p> <p>D. a provision ensuring that the soiled/decontamination and clean reprocessing areas were cleaned and</p>		<p>cleaning checklist compliance for Surgery will be reported up to Patient Safety/Safety Committee monthly starting at March 17, 2016. Reporting will occur monthly until all areas are at 100% compliance with accuracy. In relation to Surgery reporting of cleaning checklist, once three consecutive months have been completed at 100% compliance reporting will move to quarterly reporting for Surgery checklists. PM reporting for Housekeeping and Plant Operations will continue to be monthly. See Attachments 8-11 (Surgery specific daily/monthly monitoring cleaning checklists) These PMs will be incorporated into the monthly PM reporting that is submitted to the monthly Patient Safety /Safety Committee. 3. Michael Mullins, Manager of Plant Operations4. 2/18/16</p>	

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	<p>disinfected daily by designated personnel when the areas are being used</p> <p>D. an organized and methodical process for surgery cleaning to ensure all surfaces were cleaned in a manner to prevent contamination of previously disinfected surfaces</p> <p>E. the designated personnel responsible for the monthly removal and cleaning of two exhaust vents in each OR room</p> <p>3. During an interview on 1-26-16 at 0930 hours, the infection control nurse, staff A8, confirmed the surgery cleaning policy/procedure failed to indicate the identified provisions.</p> <p>4. During a tour of the restricted surgical area on 1-26-16 at 1115 hours, in the presence of the director of nursing, staff A3, and the infection control nurse, staff A8, the following was observed in OR 1: a significant accumulation of dust and particulate material was present in the grillework of the two 24" x 24" exhaust vents and a strand of suspected spiderweb extending from the OR ceiling to a power column extending down from the ceiling surface.</p> <p>5. During a tour of the restricted surgical area on 1-26-16 at 1125 hours, in the presence of the director of nursing, staff A3, and the infection control nurse, staff</p>			

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S 0602 Bldg. 00	<p>A8, the following was observed in OR 2: a significant accumulation of dust and particulate material was present in the grillework of the two 24" x 24" exhaust vents.</p> <p>6. During an interview on 1-26-16 at 1125 hours, the director of nursing, staff A3, and the infection control nurse, staff A8, confirmed that the presence of accumulated dust on the exhaust vents and the presence of the suspected spiderweb was unsanitary.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vi)</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>(vi) An isolation system. Based on document review and interview, the infection control committee failed to ensure its isolation precautions policy was followed for patients diagnosed with communicable</p>	S 0602	<p>1. Isolation patients will be identified on every Administrative End of Shift Report. Revision to the form occurred and initiated on 2/23/16. New tracking elements on the report related to isolation</p>	03/04/2016

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	<p>diseases for 1 of 16 medical records (MR) reviewed (patient #16).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The 2007 Centers for Disease Control and Prevention (CDC) publication titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings indicated the following: "Infectious agents for which Droplet Precautions are indicated are found in Appendix A and include ...group A streptococcus (for the first 24 hours of antimicrobial therapy)." 2. The policy/procedure Isolation Policy (approved 1-15) indicated the following: "Appendix A...use droplet precautions for patients known or suspected to have serious illnesses transmitted by large particle droplets. Examples of such illnesses include: ...Streptococcal pharyngitis, pneumonia, or scarlet fever in infants and young children." 3. Facility documentation indicated 72 nursing staff and secretaries were notified of new order sets for isolation precautions. The group email education and advisory sent on 11-3-15 at 1523 hours by the nursing educator, staff A13, indicated the following: "Every Isolation Patient must have an order... initiated by 		<p>patients include: isolation reason/ diagnosis, Isolation type, Isolation date/time, and Isolation CPOE order date and time. Email notification of change and form revision submitted to Nursing leadership and House Supervisors by Director of Nursing on 2/23/16. Revision to Administrative policy #112- Isolation Policy included verbiage on expectations on order receipt and entry in EMR as well as identification of type of isolation precautions warranted. On 2/22/16 Staff education was initiated on isolation ordering and entry; anticipated staff education completion date 3/4/16. See Attachments 1-5: (Revised Administrative End of Shift Report Sheet, Email notification and education by Director of Nursing, Revised page in Isolation Policy, Staff education program/sign in sheets, and Education Action plan to complete training)</p> <p>2. Nursing will monitor monthly the isolation order process. Reporting will start in March at the 3/4/16 Nursing Leadership meeting. Additional reporting will continue at the monthly Committee of the Whole meeting and the quarterly Infection Control Committee meeting. Reporting will occur monthly until compliance accuracy is at 100%. Once three consecutive months at 100% have been completed reporting will move to quarterly reporting.</p>		

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S 1024 Bldg. 00	<p>the Registered Nurse (per unit routine) if this is a weekend or time when the infection control staff are not on site. The Icon will pull in type of isolation and infection control documentation history to the census."</p> <p>4. Review of the MR documentation for patient #16 failed to indicate droplet isolation precautions were ordered and/or droplet isolation precautions were utilized by any staff between the time period when the initial positive test result was reported to ED (emergency department) physician MD21 on 12-20-15 at approximately 2230 hours or on admission on 12-21-15 at 0045 hours to room 222 of the medical-surgical unit until discharge on 12-22-15 at 1500 hours.</p> <p>5. During an interview on 1-27-16 at 1235 hours, the infection control nurse, staff A8, and the ED manager, staff A9, confirmed the MR for patient #16 failed to indicate that droplet isolation precautions were ordered or utilized (at a minimum) during the 24 hour period after the first dose of antibiotics when the patient is still considered to be infectious.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</p>		<p>See Attachments 6-7 (Nursing Leadership Agenda and Isolation monitoring tool)</p> <p>3. Marina Wolfe, Assistant Administrator and Director of Nursing</p> <p>4. 3/4/2016</p>		

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	<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 document review and interview, the pharmacy service failed to ensure all refrigerated medications were properly stored until used and failed to ensure all unusable medications were identified and removed from inventory for three of four patient care areas where refrigerated medications were maintained (the medical-surgical unit [MS], special care unit [SCU] and the emergency department [ED]).</p> <p>Findings include:</p> <p>1. The U.S. Food and Drug Administration (FDA) publication issued 5-27-15 titled Information Regarding Insulin Storage and Switching Between Products in an Emergency indicated the following: "According to the product labels from all three U. S. insulin</p>	S 1024	<p>1. Temperature Log for Refrigerators and Freezers Used for Medications Policy #752 and Union Hospital Clinton Pharmacy Policy # PP556- Storage, Handling, and Disposition of Pharmacy Items revised to include required temperature range specifications and guidance of steps to occur if temperatures become out of range. A medication temperature corrective action log was developed and added to the back page of the existing temperature logs. The log was taken to Patient Safety/Safety Committee on 2/17/16 and was approved. Clinical staff education on the temperature corrective action log scheduled to begin 2/29/16 with anticipated completion date 3/4/2016. See Attachments: 1-5 (Policy #752, Policy PP556, Temp log with</p>	03/04/2016

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	<p>manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36o Fahrenheit (F) to 46o F...[and]...Do not use insulin that has been frozen."</p> <p>2. The Centers for Disease Control and Prevention (CDC) publication issued 10-24-03 titled Notice to Readers: Guidelines for Maintaining and Managing the Vaccine Cold Chain indicated the following: "The majority of commonly recommended vaccines require storage temperatures of 35o F to 46o F (2o Centigrade (C) to 8o C) and must not be exposed to freezing temperatures. ...Freezing temperatures can irreversibly reduce the potency of vaccines required to be stored at 35o F to 46o F (2o C to 8o C)."</p> <p>3. The policy/procedure Storage, Handling and Disposition of Pharmacy Items (approved 2-15) indicated the following: "Refrigerated Items - Any item that the manufacturer states must or should be refrigerated will be kept in the refrigerator at 32 to 40 degrees Fahrenheit. The temperature will be checked daily and recorded on a daily log sheet."</p> <p>4. During an interview on 1-27-16 at 0940 hours, the chief nursing officer,</p>		<p>Corrective Action Log, Education Action Plan/timeline for Staff on topic and Safety agenda). 2. Quality Management currently monitors quality control checks from all locations. This includes medication refrigerator/freezers logs and compliance with daily documentation of temperatures. Quality Management will add reporting line for each area with medication refrigerator/freezer logs and noting any discrepancy in temperature ranges and assess if appropriate actions were taken and documented as per policy. This information will be reported up to Patient Safety/Safety Committee monthly starting at March 17, 2016 meeting. Reporting will occur monthly until all areas are at 100% compliance with accuracy. Once three consecutive months at 100% have been completed reporting will move to quarterly report. 3. Penny Jackson, UHC Pharmacy/IV Coordinator4. 3/4/2016</p>		

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	<p>staff A2, confirmed the temperature range indicated in the facility policy was not consistent with the FDA and CDC recommendations for refrigerated storage of insulins and vaccines as identified above.</p> <p>5. The policy/procedure Temperature Log for Refrigerators and Freezers used for Medications (approved 4-13) indicated the following: "In the event the temperature reading is outside the acceptable range or trending toward the acceptable limits, the thermostat will be adjusted... All actions will be noted on the Medication Refrigerator Temperature Log or the Medication Freezer Temperature Log ...In the event a refrigerator or freezer malfunctions, Pharmacy will be called to determine which medications need to be destroyed. Related Documents: None." The policy/procedure failed to indicate the following: A. the acceptable range for proper storage of refrigerated medications B. the temperature limits for acceptable storage of refrigerated medications C. a corrective action to take when the lower temperature limit has been exceeded</p> <p>6. Review of the monthly temperature logs for October, November, and</p>			

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	<p>December 2015 for the areas of pharmacy, MS, SCU and ED indicated the following:</p> <p>A. The October 2015 log for the MS unit recorded a 0oC reading (32oF) on 10-30 and indicated the house supervisor and maintenance were notified. The log failed to indicate the thermostat was adjusted.</p> <p>B. The October 2015 log for the MS unit recorded a -2oC reading (29oF) on 10-31 and indicated that maintenance was aware. The log failed to indicate that pharmacy was contacted or otherwise indicate any medications or vaccines were destroyed.</p> <p>C. The November 2015 log for the SCU unit recorded a -1oC reading (31oF) on 11-05 and indicated the thermostat was adjusted. The log failed to indicate that pharmacy was contacted or indicate any medications or vaccines were destroyed.</p> <p>D. The November 2015 log for the ED unit recorded a -1oC reading (31oF) on 11-03 and indicated the temperature was rechecked at an unknown time and observed in the acceptable range. The log failed to indicate that pharmacy was contacted or indicate any medications or vaccines were destroyed.</p> <p>7. During an interview on 1-27-16 at 1035 hours, the medical-surgical manager, staff A10, confirmed that the</p>			

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S 1118 Bldg. 00	<p>MS refrigerator contained vaccines and confirmed that the refrigerated medications were not disposed of when exposed to freezing temperatures in October 2015.</p> <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 document review, observation and interview, the clinical engineering service failed to ensure that the negative airflow airborne isolation rooms were maintained and/or available for use at the facility.</p> <p>Findings include:</p> <p>1. The American Institute of Architects (2001 edition) Guidelines for Design and Construction of Hospital and Health Care Facilities indicated the following: "7.2. Nursing Unit (Medical and Surgical) 7.2.C7. [Airborne infection isolation]</p>	S 1118	<p>1. Installed visual mechanisms "Ball in the Wall" for rooms 202, 208, and 209 to provide constant monitoring of pressure status in isolation/negative air pressure rooms. Installation completed on 2/15/16. Plant Staff in-service on visual mechanism completed on 2/16/16. Clinical and Service Staff in-service on visual mechanism initiated 2/22/16 with anticipated education completion of all staff by date 3/4/16. Scope of Work for construction of ER Room # 4 conversion to isolation/negative air pressure room approved on 2/22/16. Construction to begin on 3/2/16 with anticipated completion date</p>	03/12/2016

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	<p>Rooms shall have a permanently installed visual mechanism to constantly monitor the pressure status of the room when occupied by patients with an airborne infectious disease. The mechanism shall continuously monitor the direction of the airflow. ...7.9. Emergency Service 7.9.C.7. Airborne Infection Control. At least one airborne infection isolation room shall be provided as described in table 7.2 and paragraphs 7.2.C3, 7.2.C4, 7.2.C6, and 7.2.C7."</p> <p>2. The policy/procedure Airborne Precautions (approved 2-15) indicated the following: "Patients will be placed in airborne precaution isolation, single-patient room with negative pressure ventilation, with a minimum of 12 air exchanges per hour, and the room exhausted directly to the outside. ...Negative pressure isolation rooms available at ...[the facility are] ...208, 209, and SCU-2 (special care unit). ...Monitoring of Isolation. The maintenance department will check the negative air pressure daily when airborne precautions are in effect." The policy/procedure failed to indicate a negative pressure isolation room was available for the Emergency Department (ED) if needed and failed to indicate a visual indicator was available to monitor the airflow status when occupied by</p>		<p>3/12/16. Plant Operations will install "Ball in the Wall" system to new ER isolation/negative air pressure room once construction is completed. ER Staff and Physician education in-service on visual mechanism to be completed after construction completion date. Airborne Precautions Administrative policy # 226 and Administrative Tuberculosis Exposure Control Plan policy # 337 revised to reflect change in process. Policies will be presented to Infection Control Committee for recommended approval on 3/10/16. See Attachments 1-8: (Airflow Detection Flow Invoice, picture Ball in the Wall device, work order for Ball in the Wall, Education sheets for staff, Scope of Work for ER Room, Approval for ER project, policy #226 and policy # 337)2. PM monitoring will occur as per Airborne Precautions policy #226 for isolation/negative air pressure rooms (202. 208, 209, and ER#4) and will be tracked and reported by Plant Operations quarterly to Infection Control Committee and incorporated into the PM Compliance report that is submitted monthly to Patient Safety/Safety Committee. Nursing will monitor monthly for nursing progress note documentation of initial visual inspection by staff of negative air pressure check prior to placement of patient in room.</p>		

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S 1164 Bldg. 00	<p>patients with an airborne infectious disease.</p> <p>3. During a tour of the ED on 1-26-16 at 1240 hours, in the presence of the director of nursing, staff A3, the lack of a negative airflow isolation room or visual indicator to monitor the airflow status was identified.</p> <p>4. During an interview on 1-27-16 at 0930 hours, the physical plant manager, staff A5 confirmed that the ED lacked a negative airflow airborne isolation room.</p> <p>5. During a tour of the medical surgical unit on 1-26-16 at 1310 hours, in the presence of the director of nursing, staff A3, and the infection control nurse, staff A8, the lack of a visual indicator to monitor the airflow status for the negative airflow isolation rooms 208, 209 and SCU-2 was identified.</p> <p>6. During an interview on 1-26-16 at 1310 hours, the director of nursing, staff A3, confirmed the negative airflow rooms lacked a visual indicator to monitor the airflow status.</p>		<p>This monitoring will be reported to monthly to Patient Safety/Safety Committee. Reporting will occur monthly until compliance accuracy is at 100%. Once three consecutive months at 100% have been completed reporting will move to quarterly reporting. In addition, Artec Environment services has been contracted to complete semi-annual air flow checks that will be reported to respective committees. See Attachments- 9 &10 (Plant Daily Air Flow Checks monitoring tool and Nursing Documentation of Negative Air Flow by Nursing monitoring tool) 3. Michael Mullins, Manager of Plant Operations4. 3/12/16</p>		
	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)				

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	<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. Based on document review and interview, the hospital failed to have evidence of monthly preventive maintenance on the automatic floor scrubbers.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of Clark's Automatic Floor Scrubber indicated each battery should be checked weekly; squeegee blade checked and replaced if needed; and the motor should be lubricated monthly. Review of the preventive maintenance inspections of the hospital's automatic floor scrubber indicated it was only checked semi-annually. The hospital failed to have any documented evidence that the floor scrubber was checked weekly as recommended by the manufacturer. In interview at 1:10 PM on 1/26/2016, staff member #5 (Maintenance Manager) 	S 1164	<p>1. 2/5/16-Plant Operations initiated monthly, weekly, and a daily PM as per the scrubber/polisher operator manual maintenance schedule. Daily/weekly PMs were incorporated into a checklist that will be completed by Housekeeping staff. Plant Operations will complete the monthly PM. Staff education on the new daily/weekly PM checklist was completed at the Housekeeping Department meeting on 2/11/16. (See Attachments 1-4: Operators Manual, PM Work Order, Daily/Weekly Checklist, and Housekeeping Dept Agenda and Sign in sheet)2. Housekeeping will submit monthly completed daily/weekly PM checklist to Plant Operations. Plant Operations will review and maintain the forms. The monthly, weekly, and daily PM requirements and compliance will be added to the required PM reporting from Plant Operations that gets submitted for review at the monthly Patient Safety/Safety</p>	02/11/2016

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	confirmed all the above and no other documentation was provided prior to exit.		Committee meeting. Expected PM compliance to be at 100%. 3. Michael Mullins, Manager of Plant Operations4. 2/11/16		