

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
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NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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S000000	<p>This visit was for the investigation of three (3) licensure complaints.</p> <p>Dates of survey: 03/12/14 through 03-13-14</p> <p>Facility number: 004975</p> <p>Complaint number: IN00144872 Substantiated; State deficiencies related to allegations cited IN00144124 Substantiated; State deficiencies related to allegations cited IN00140332 Substantiated; State deficiencies related to allegations cited</p> <p>Surveyors: Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: cloughlin 03/25/14</p>	S000000		
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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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S000308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the facility failed to provide department specific orientation for one (1) staff member (staff #F).</p> <p>Findings include;</p> <p>1. Staff member #F personnel file lacked evidence of department specific orientation. He/she was hired 1/7/14.</p> <p>2. Staff member #3 indicated the following in interview beginning at 3:10 p.m. on 3/13/14: (A) He/she verified there were no dietary orientation documents for staff member #F.</p>	S000308	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S308 DATE DEFICIENCY WILL BE CORRECTED: 04/09/2014 WHO IS RESPONSIBLE: DAVE MILLET (FACILITIES DIRECTOR) DOUG LEE (HUMAN RESOURCES DIRECTOR) WHAT IS THE PLAN OF CORRECTION: DEPARTMENT SPECIFIC ORIENTATION WILL BE COMPLETED AND MAINTAINED ON ALL DIETARY EMPLOYEES WHEN THE PLAN OF CORRECTION WILL BEGIN: 04/09/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: DAVE MILLET (FACILITIES DIRECTOR) WILL ENSURE ALL DIETARY EMPLOYEES HAVE RECEIVED DEPARTMENT SPECIFIC ORIENTATION</p>	04/09/2014
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S000560	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(d) (d) A person qualified by training or experience shall be designated as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on document review and staff	S000560	USING THE DIETARY DEPARTMENT SPECIFIC ORIENTATION CHECKLIST. COPIES OF THESE COMPLETED CHECKLISTS WILL BE MAINTAINED IN THE OFFICE OF THE FACILITIES DIRECTOR, AS WELL AS IN EACH INDIVIDUAL EMPLOYEE FILE IN HUMAN RESOURCES. EACH DEPARTMENT DIRECTOR WILL BE RESPONSIBLE FOR MONITORING THE DEPARTMENT SPECIFIC ORIENTATION OF ALL NEW EMPLOYEES IN THEIR DEPARTMENT. EACH DEPARTMENT DIRECTOR WILL ENSURE THAT THE DEPARTMENT SPECIFIC ORIENTATION CHECKLIST IS COMPLETED AND PLACED IN THE EMPLOYEE FILE IN HUMAN RESOURCES UPON COMPLETION OF DEPARTMENT ORIENTATION AND BEFORE THE EMPLOYEE IS GIVEN A DEPARTMENT WORK SCHEDULE. ISDH PLAN OF CORRECTION	04/21/2014	

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	<p>interview, the infection control officer failed to ensure the isolation precautions policy was followed for 1 patient on the behavioral health unit (BHU) with an infection (patient #6).</p> <p>Findings include;</p> <p>1. Facility policy titled "Isolation Precautions" last reviewed/revised 6/13 states on page 3 under Contact Precautions: "Used in addition to Standard Precautions for patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with patient..... Examples of such conditions include:.....MRSA." Under patient care, the document indicates care will include, but is not limited to, patients out of room for essential purposes only...."</p> <p>2. Review of patient #6 medical record indicated he/she had MRSA to a wound.</p> <p>3. Staff member #172 indicated the following in interviews beginning at 1:40 a.m. on 3/12/14: (A) Isolation patients are among general population depending on who you work with. Certain staff will keep patients in their rooms while others will allow them</p>		<p>STATE TAG ID: S560</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 04/21/2014</p> <p>WHO IS RESPONSIBLE: GINGER OTTERSACH, RN, CNO</p> <p>WHAT IS THE PLAN OF CORRECTION:</p> <p>STAFF EDUCATION REGARDING ISOLATION OF PATIENTS</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 04/16/2014</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p> <p>NURSING STAFF AND NURSING ASSISTANTS WERE GIVEN AN INSERVICE ON THE CURRENT POLICY AND CORRECT PROCEDURES FOR ISOLATION PATIENTS. EACH OF THESE STAFF MEMBERS SIGNED AN ACKNOWLEDGEMENT SHEET AND THIS WILL BE MAINTAINED BY THE CNO AND A COPY OF THIS WILL ALSO BE MAINTAINED IN THE QUALITY OFFICE.</p> <p>ISOLATION POLICY AND PROCEDURES WILL BE INCLUDED IN NURSING</p>	
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S000610	<p>to be out. Patient #6 had an infection and some days was allowed out of room while others he/she was told to keep the patient in their room.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 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>ANNUAL SKILLS DAY CHECK OFF STATIONS AND DOCUMENTATION THAT ALL NURSING STAFF HAS RECEIVED ANNUAL UPDATES ON THESE PROCEDURES WILL BE MAINTAINED WITH THE ANNUAL SKILLS DAY PACKET KEPT ON EACH NURSING STAFF MEMBER. SIGN IN SHEETS FOR ANNUAL SKILLS DAY WILL BE MAINTAINED AS DOCUMENTATION OF ATTENDANCE.</p>	

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	<p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation and document review, the infection control committee failed to ensure staff members followed standards for food handling in 2 instances observed.</p> <p>Findings include;</p> <p>1. The following was observed during tour of the facility which began 10:50 a.m. on 3/12/14:</p> <p>(A) Lunch was brought to the unit on a covered cart. Staff member #27 was delivering food to the patients and touching the rolls on the plates without gloves.</p> <p>(B) Staff member #D1 did not wash hands between task in the kitchen. He/she went from 3 compartment washing sink, to removing food from oven, to checking food temps without handwashing.</p> <p>2. Staff member #27 indicated the following in interview beginning at 12:10 p.m. on 3/12/14:</p> <p>(A) He/she was not trained on how to handle patient trays.</p> <p>(B) He/she indicated that they did not wash their hands before preparing a tray</p>	S000610	<p>ISDH PLAN OF CORRECTION</p> <p>STATE TAG ID: S610</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 04/21/2014</p> <p>WHO IS RESPONSIBLE: DAVE MILLET (FACILITIES DIRECTOR) GINGER OTTERSBUCH (CNO)</p> <p>WHAT IS THE PLAN OF CORRECTION:</p> <p>NURSING AND DIETARY STAFF EDUCATION REGARDING SAFE FOOD HANDLING AND SANITIZING AREAS WHERE FOOD IS CONSUMED BY THE PATIENTS</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 04/16/2014</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p> <p>DAVE MILLET (FACILITIES DIRECTOR) AND GINGER OTTERSBUCH, CNO WILL EDUCATE STAFF ON THE SAFE AND PROPER PROCEDURE FOR FOOD HANDLING AND SANITIZING OF TABLES AND AREAS</p>	04/21/2014			

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	<p>for a patient and touching the patients food.</p> <p>3. 410 IAC 7-24-129 states "Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils.....; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; after engaging in other activities that contaminate the hands."</p> <p>4. 410 IAC 7-24-171 states "Food employees shall not contact exposed, ready-to-eat food with hands that have not been washed and shall use suitable utensils, such as: deli tissue; spatulas; tongs, single-use gloves."</p>		<p>WHERE FOOD IS CONSUMED BY THE PATIENTS, INCLUDING BUT NOT LIMITED TO WEARING OF GLOVES WHEN HANDLING PATIENT FOOD AND PROPER HANDWASHING DURING FOOD HANDLING AND PREPARATION, AND THE USE OF SANITIZING WIPES TO CLEAN TABLES BETWEEN MEALS. THESE EMPLOYEES WILL SIGN DOCUMENTATION THAT THEY HAVE RECEIVED AND UNDERSTAND THIS EDUCATION AND THE SIGNATURES WILL BE KEPT IN THE OFFICE OF THE CNO AND FACILITIES DIRECTOR.</p> <p>POLICY AND PROCEDURES FOR FOOD HANDLING AND SANITIZING AREAS WHERE FOOD IS CONSUMED WILL BE INCLUDED IN EMPLOYEE ANNUAL SKILLS DAY CHECK OFF STATIONS AND DOCUMENTATION THAT ALL NURSING AND DIETARY STAFF HAS RECEIVED ANNUAL UPDATES ON THESE PROCEDURES WILL BE MAINTAINED WITH THE ANNUAL SKILLS DAY PACKET KEPT ON EACH STAFF MEMBER. SIGN IN SHEETS FOR ANNUAL SKILLS DAY WILL BE MAINTAINED AS DOCUMENTATION OF ATTENDANCE.</p>		

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S000612	<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. Based on observation, document review and interviews, the facility failed to ensure laundry services were provided according to facility policy and standard of practice for one (1) in house laundry service.</p> <p>Findings include;</p> <p>1. The laundry room outside the BHU and utilized by BHU staff lacked a handwashing sink or hand sanitizer in the room.</p> <p>2. CDC document titled "Guidelines for environmental infection control in healthcare facilities" states "Ensure that laundry areas have handwashing facilities and products and</p>	S000612	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S612 DATE DEFICIENCY WILL BE CORRECTED: 04/16/2014 WHO IS RESPONSIBLE: DAVE MILLET (FACILITIES DIRECTOR) GINGER OTTERSBAACH (CNO) WHAT IS THE PLAN OF CORRECTION: HANDWASHING SINK AND HAND SANITIZER DISPENSER IN THE LAUNDRY AREA ON BEHAVIORAL HEALTH UNIT EMPLOYEE EDUCATION ON BEHAVIORAL UNIT LAUNDRY POLICY AND PROCEDURES WHEN THE PLAN OF CORRECTION WILL BEGIN: 04/15/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: A HANDWASHING SINK WAS INSTALLED IN THE LAUNDRY AREA ON THE BEHAVIORAL</p>	04/16/2014			

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	<p>appropriate PPE available for workers..... Category IC (AIA: 7.23.D4; OSHA: 29 CFR 1910.1030 Â§ d.2.iii)"</p> <p>3. Facility policy titled "Patient Laundry" effective 3/14 indicates patient laundry will be washed separately and a disinfect cycle of bleach will be performed after each load of laundry.</p> <p>4. Staff member #110 indicated the following in interviews that began at 1:40 p.m. on 3/12/14: (A) He/she does not use bleach between wash cycles when washing patient laundry.</p> <p>5. Staff member #62 indicated the following in interviews beginning at 1:40 p.m. on 3/12/14: (A) He/she thinks the detergent used has bleach in it and he/she wipes the inside of the washer/dryer with bleach after use. He/she has ran a bleach cycle "at times".</p>		<p>UNIT, ALONG WITH A HAND SANITIZER DISPENSER, AND ALL PPE HAS BEEN MADE AVAILABLE IN THIS LAUNDRY AREA IN ORDER FOR EMPLOYEES TO USE STANDARD PRECAUTIONS WHILE HANDLING PATIENT BELONGINGS. BEHAVIORAL HEALTH UNIT LAUNDERING POLICY WILL DEFINE POLICY AND PROCESS FOR LAUNDERING PATIENT'S CLOTHING USING SUN DETERGENT AND CHLORINE BLEACH. THIS POLICY WILL BE SUMMARIZED WITH AN INSTRUCTION SHEET POSTED IN THE BHS LAUNDRY ROOM WITH CLEAR INSTRUCTIONS ON THE PROCESS FOR LAUNDERING PATIENT CLOTHING INCLUDING: SUN DETERGENT AND CHLORINE BLEACH MANUFACTERER'S RECOMMENDED AMOUNT OF DETERGENT TO USE TO PROPERLY CLEAN THE CLOTHING SPECIFIC INSTRUCTIONS THAT EACH PATIENT'S CLOTHES ARE TO BE LAUNDERED INDIVIDUALLY INSTRUCTIONS FOR A BLEACH CYCLE TO BE RAN AFTER EACH PATIENT WASH LOAD TO PROPERLY DISINFECT THE WASHER BETWEEN LOADS, INCLUDING THE AMOUNT OF BLEACH TO USE INSTRUCTIONS FOR SIGNING A DAILY LOG THAT WILL DOCUMENTATION OF</p>				

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			<p>INCLUDE EACH PATIENT LOAD WASH ALONG WITH DOCUMENTATION OF EACH BLEACH CYCLE LOAD FOLLOWING EACH PATIENT LOAD INSTRUCTIONS ON PROPER PPE TO BE WORN WHEN HANDLING A PATIENT'S SOILED CLOTHING THIS POLICY WAS DEVELOPED AND APPROVED BY INFECTION CONTROL COMMITTEE AND MONITORING OF THIS PROCEDURE WILL BE DONE BY MONTHLY TRACKING OF THE LAUNDERING AND WASHER DISINFECTING LOG TO ENSURE COMPLIANCE WITH EACH LOAD OF PATIENT LAUNDRY DONE. THE RESULTS OF THIS MONITORING WILL BE REPORTED TO INFECTION CONTROL COMMITTEE QUARTERLY TO EVALUATE METHOD, COMPLIANCE, AND FOR NECESSARY POLICY REVISIONS. ALL EMPLOYEES WERE INSERVICED ON THIS NEW LAUNDRY POLICY AND PROCEDURES FOR WASHER DISINFECTING, INCLUDING PROPER PPE TO BE WORN WHEN HANDLING SOILED OR WORN PATIENT CLOTHING. ALL EMPLOYEES SIGNED DOCUMENTATION THAT THEY RECEIVED THIS INSERVICE. LAUNDRY POLICY AND PROCEDURES WILL BE INCLUDED IN NURSING ANNUAL SKILLS DAY CHECK</p>	

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S000930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, the facility failed to ensure a registered nurse evaluated the care provided to 1 of 5 patients. (Patient #5)</p> <p>Findings include;</p> <p>1. Review of patient #5 medical record indicated the following: (A) He/she weighed 140 pounds on admission date of 2/13/14. (B) An order was written on 2/13/14 for weekly weights. (C) The medical record lacked documentation that the patient was weighed after the admission weight on 2/13/14 and he/she was discharged on 3/4/14.</p>	S000930	<p>OFF STATIONS AND DOCUMENTATION THAT ALL NURSING STAFF HAS RECEIVED ANNUAL UPDATES ON THESE PROCEDURES WILL BE MAINTAINED WITH THE ANNUAL SKILLS DAY PACKET KEPT ON EACH NURSING STAFF MEMBER. SIGN IN SHEETS FOR ANNUAL SKILLS DAY WILL BE MAINTAINED AS DOCUMENTATION OF ATTENDANCE.</p> <p>ISDH PLAN OF CORRECTION</p> <p>STATE TAG ID: S930</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 04/25/2014</p> <p>WHO IS RESPONSIBLE: GINGER OTTERSBACK, RN, CNO</p> <p>WHAT IS THE PLAN OF CORRECTION:</p> <p>DAILY CHART CHECK FOR PHYSICIAN ORDER ACCURACY</p>	04/17/2014	

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S000934	<p>2. Staff member #190 verified in interview at 1:58 p.m. on 3/13/14 that patient #5 had no weight documented other than the weight on 2/13/14.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(b)(5)</p> <p>(b) The nursing service shall have the following:</p> <p>(5) A registered nurse shall assign</p>		<p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 04/25/2014</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p> <p>POLICY FOR DAILY CHART CHECKS TO ENSURE ALL PHYSICIAN ORDERS ARE RECEIVED, NOTED AND CARRIED OUT IS IN PLACE TO ENSURE THAT ALL PHYSICIAN ORDERS ARE FOLLOWED. THIS AUDIT WILL BE DONE EVERY 24 HOURS ON ALL CHARTS. THIS POLICY WILL BE PRESENTED TO ALL NURSING STAFF BY READ AND SIGN EDUCATION METHOD AND WILL BE INCLUDED IN ANNUAL SKILLS DAY CHECK OFF STATIONS. DOCUMENTATION THAT ALL NURSING STAFF HAS RECEIVED ANNUAL UPDATES ON THIS CHART CHECK POLICY AND PROCEDURE WILL BE MAINTAINED WITH THE ANNUAL SKILLS DAY PACKET KEPT ON EACH NURSING STAFF MEMBER.</p>		

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NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the care of each patient to nursing personnel in accordance with the patient's need and the specialized qualifications and competence of the nursing staff available.</p> <p>Based on document review and interviews, the facility failed to ensure that all nursing staff assigned to telemetry patients received telemetry training for 2 of 4 telemetry patients. (patients #1 and 4)</p> <p>Findings include;</p> <ol style="list-style-type: none"> 1. Review of patient #1 medical record indicated he/she was on telemetry and staff assigned to the patient included, but was not limited to, staff #N1 and N2. 2. Review of patient #4 medical record indicated he/she was on telemetry and staff assigned to the patient included, but was not limited to, staff member #N3. 3. Review of telemetry education documents indicated that staff members #N1, N2, and N3 had not completed the telemetry training. 4. Facility policy titled "TELEMETRY, CARE OF PATIENT" last reviewed/revised 1/09 states on page 1: "After initiating Telemetry monitoring, run a rhythm strip and place on mounting form. Rhythm strips are then run ever (known error) four hours thereafter. PRN rhythm strips should be run if the patient shows rhythm changes, or if the patient's condition warrants." Page 2 states "A Telemetry trained nurse will interpret the rhythm strip once it is mounted." 5. Staff member #1 indicated in interview at 1:50 p.m. on 3/13/14 that staff members #N1, N2, and N3 had not received telemetry training. 	S000934	<p>ISDH PLAN OF CORRECTION</p> <p>STATE TAG ID: S934</p> <p>DATE DEFICIENCY WILL BE CORRECTED:</p> <p>4/25/2014</p> <p>WHO IS RESPONSIBLE: GINGER OTTERSBACK, RN, CNO, RAYMOND WOODS, RN</p> <p>WHAT IS THE PLAN OF CORRECTION:</p> <p>NURSING STAFF TELEMETRY TRAINING</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN:</p> <p>4/25/2014</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p> <p>ALL NURSING STAFF CARING FOR TELEMETRY PATIENTS WILL RECEIVE DOCUMENTED TRAINING REGARDING THE CARE OF PATIENTS ON TELEMETRY MONITORS. THIS TRAINING WILL INCLUDE HOW TO INTERPRET TELEMETRY STRIPS AND DOCUMENT THE INTERPRETATION IN THE</p>	04/25/2014

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S001118	<p>6. Staff member #190 verified in interview at 1:58 p.m. on 3/13/14 that staff members #N1 and N2 cared for telemetry patient #1 and staff member #N3 cared for telemetry patient #4.</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 observation, interview, and document review, the facility failed to maintain the physical environment throughout the facility.</p> <p>Findings include;</p>	S001118	<p>PATIENT RECORD. THIS TRAINING WILL HAVE A DOCUMENTED AGENDA AND SIGN IN SHEET TO CONFIRM ATTENDANCE AND COURSE CONTENTS. ANNUAL UPDATES ON CARE OF TELEMETRY PATIENTS AND STRIP INTERPRETATION WILL BE INCLUDED IN NURSING ANNUAL SKILLS DAY CHECK OFF STATIONS AND DOCUMENTATION THAT ALL NURSING STAFF HAS RECEIVED ANNUAL UPDATES ON THESE PROCEDURES WILL BE MAINTAINED WITH THE ANNUAL SKILLS DAY PACKET KEPT ON EACH NURSING STAFF MEMBER.</p> <p>ISDH PLAN OF CORRECTION STATE TAG ID: S1118 DATE DEFICIENCY WILL BE CORRECTED: 4/23/2014 WHO IS RESPONSIBLE: DAVE MILLET (FACILITIES MANAGEMENT) WHAT IS THE</p>	04/23/2014	

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	<p>1. The following was observed during tour of the facility which began 10:50 a.m. on 3/12/14 and continued on 3/13/14. "Occupied" rooms indicate the room was assigned to a patient and not necessarily that a patient was in the room while on tour.</p> <p>(A) The hallway near room 317 on the behavioral health unit (BHU) had no baseboard and had white putty and incomplete drywall work evident.</p> <p>(B) Room 317 (unoccupied at time of tour and no patient assigned to room) did not have a functioning heating unit per staff member #3.</p> <p>(C) Room 316 (occupied by a patient who was in the bed at the time of tour) did not have a functioning heating unit per staff members #1 and #3.</p> <p>(D) Room 314 (unoccupied at time of tour and occupied the previous week per census report) had drywall work in progress and unfinished. The ceiling was bowed and water stained around "pull down hatch" for heating and cooling unit.</p> <p>(E) Room 313 (occupied) had evidence of water damage to the ceiling with seven (7) brown stained ceiling tiles noted.</p> <p>(F) Room 315 (occupied) had evidence of water damage to the ceiling with four (4) brown stained ceiling tiles. The room also had evidence of unfinished drywall repair.</p>		<p>PLAN OF CORRECTION: REPAIR OF ALL STRUCTURAL AND COSMETIC DEFICIENCIES FOUND WITHIN THE FACILITY. UPDATING OF FACILITY PLANS REGARDING ENVIRONMENTAL INSPECTIONS, AND REVISIONS OF UTILITIES MANAGEMENT POLICIES.</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN: 4/7/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: HEATING AND AIR CONDITIONING UNIT REPLACEMENT IN ROOMS 316 AND 317 BEGAN ON 4/7/2014 AND WAS COMPLETED ON 4/9/2014. THE DRYWALL, BASEBOARD, HAND RAIL AND WALL COSMETIC REPAIRS BEGAN ON 4/7/2014 AND WILL BE COMPLETED ON 4/23/2014. ROOF REPLACEMENT WAS BEGAN ON 4/16/2014 AND WILL BE COMPLETED ON 4/26/2014. CEILING TILE REPLACEMENT BEGAN ON 4/7/2014. ALL STAINED TILES WERE REPLACED. ANY STAINS FOUND AFTER 4/26/2014 WILL BE REPLACED FOLLOWING THE COMPLETION OF THE ROOF REPLACEMENT ON 4/26/2014. THE ENVIRONMENTAL TOURS WERE REINSTATED ON 4/14/2014 USING A PRE ESTABLISHED INSPECTION CHECKLIST AND WILL BE COMPLETED ON A MONTHLY BASIS. DOCUMENTATION OF</p>		

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	(G) Room 312 (occupied) had evidence of a hole in the drywall and an outlet hanging from wall. (H) Room 311 (occupied) had evidence of unfinished drywall work. The ceiling had evidence of water damage on seven (7) brown stained ceiling tiles. (I) The soiled utility room had evidence of unfinished drywall repair and the baseboard was off and on the floor. (J) Room 306 (occupied) had evidence of unfinished drywall repair. The solid ceiling had evidence of water damage. (K) Room 307 (occupied) had evidence of unfinished drywall repair. The ceiling had evidence of water damage on one (1) brown stained ceiling tile. The bathroom had missing tiles on the floor inside the door. (L) The hallway outside room 307 had three (3) holes visible in the drywall and no handrail. Per staff member #3, the holes are from where the handrail was mounted previously. (M) Room 305 (occupied) had evidence of unfinished drywall repair with a hole evident in the wall and the baseboard torn off and on the floor. (N) Room 304 (occupied) had evidence of unfinished drywall repair and telephone wiring exposed behind the head of the bed. (O) Room 303 (occupied) had evidence of unfinished drywall repair.		THESE TOURS WILL BE MAINTAINED IN THE OFFICE OF THE FACILITIES MANAGEMENT. UTILITIES MANAGEMENT POLICY AND PROCEDURE MANUAL WAS REVIEWED AND/OR REVISED ON 3/18/14.		

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	<p>(P) Room 302 (occupied) had evidence of unfinished drywall repair.</p> <p>(Q) Room 301 (occupied) had evidence of unfinished drywall repair.</p> <p>(R) The hyperbaric chamber room on the 3rd floor had evidence of water damage to three (3) brown stained ceiling tiles.</p> <p>(S) The supply room (previous laundry room) on the BHU had evidence of unfinished drywall repair, a solid surface ceiling that was cracked, open vents in the ceiling, and an uncovered ceiling light fixture. on</p> <p>(T) The AR or seclusion room #1 on the BHU had evidence of water damage to both the ceiling which was brown stained and the walls which had loose wallcoverings.</p> <p>(U) Room 318 (occupied) had evidence of water damage to one (1) ceiling tile. Additionally, the thermostat was set to 80 and the air was 68 degrees.</p> <p>(V) Room 319 (occupied) had evidence of unfinished drywall work and had a grossly stained mattress cover with brown substance.</p> <p>(W) Rooms 5 and 6 in the emergency department (ED) had cracks by the light fixture and a sagging ceiling. .</p> <p>(X) Tour of the med/surg unit revealed a dry erase board mounted on the wall that indicated rooms 211, 212, 217, 218, 220, 221, 223, 226, and 230 were "not available." Per staff member #3, it could</p>						

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	<p>be because of the bed or the heat/ac unit.</p> <p>(Y) The bulk storage area had four (4) brown ceiling tiles in the corner with evidence of water damage.</p> <p>(Z) Room 367 within the ambulatory care unit (ACU) had a large ceiling tile out exposing pipes and wires and the cover to the light fixture was hanging from the ceiling.</p> <p>(AA) The laundry room outside the BHU and utilized by BHU staff had a large (3 foot in diameter) hole in the ceiling exposing wires.</p> <p>2. Staff member #40 indicated the following in interviews beginning at 1:40 p.m. on 3/12/14: (A) He/she indicated that there used to be a lot of rooms closed on BHU because they did not have heat, however they are open now with exception of room 14. (B) Patients, families, and staff complain that it is too cold on the unit. This has been reported to staff members #3 and #4. (C) When it rains heavily, water leaks into the rooms where the vents or shafts are on the ceiling and a bucket has to be placed. It leaks every time it rains heavily.</p> <p>3. Staff member #10 indicated the following in interviews beginning at 1:40 p.m. on 3/12/14:</p>			

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	<p>(A) One a.m. there were soaked tiles from water leaks that began to fall down. One room had to be closed due to water seeping into the wall. There have been no heavy rain lately to cause leaks.</p> <p>(B) There are 2 rooms blocked off on the BHU because they have no heat.</p> <p>(C) He/she has never seen drywall repair completed/painted. Areas are just patched.</p> <p>4. Staff member #110 indicated the following in interviews beginning at 1:40 p.m. on 3/12/14: (A) At one time, there were 4-6 rooms that had no heat in them on the BHU. (B) There was a ceiling leak in the sitting room that caused the ceiling tiles to fall. The area had to be blocked off.</p> <p>5. Staff member #120 indicated the following in interviews beginning at 1:40 p.m. on 3/12/14: (A) There are water leaks on the BHU. If there is a "good rain", it will leak somewhere. (B) There have been rooms closed off on the unit because there was no heat.</p> <p>6. Staff member #62 indicated the following in interview beginning at 1:40 p.m. on 3/12/14: (A) He/she has not seen much work completed to drywall on the unit, just</p>				

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	<p>patching.</p> <p>(B) Several months ago there were leaks on the unit and ceiling tiles came down.</p> <p>7. Staff member #140 indicated the following in interviews beginning at 1:40 p.m. on 3/12/14: (A) There are a lot of water leaks in the facility. He/she has saw the damage from the leaks but not dripping.</p> <p>8. Staff member #55 indicated the following in interviews beginning at 1:40 p.m. on 3/12/14: (A) Aware of water leaks on the BHU. The facility needs a new roof over that area. The ceilings leak with rain or melting ice. (B) The 2 "end rooms" on BHU have no heat. (C) Drywall repair has been going on for over a year. There has been no painting nor does the facility have the paint to paint the rooms. (D) Areas in need of work are the A/C/heater repairs and the roof.</p> <p>9. Staff member #115 indicated the following in interviews beginning at 1:40 p.m. on 3/12/14: (A) Sometimes the patient rooms leak on BHU. There have been multiple leaks with heavy rains.</p>			

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	<p>10. Staff member #3 indicated the following in interview beginning at 3:10 p.m. on 3/13/14:</p> <p>(A) There have been leaks in the facility off and on for 6-7 months with the cause of the leaks being the roof which is in need of repair and is on the list to repair, however there are no funds for the repair.</p> <p>(B) He/she has not had a safety walk through for "about 6 months" and no environmental tours are performed at this time.</p> <p>(C) There are no current work orders for drywall repair. Drywall completion is ongoing on BHU.</p> <p>(D) Rooms 316 and 317 do not have a functioning heating unit.</p> <p>(E) He does not do any type of PM on the McQuay Air Conditioning systems because there is no way to do it.</p> <p>11. Staff member #1 indicated the following in interview beginning at 10:40 a.m. on 3/12/14:</p> <p>(A) Patient room #316 gets heat from the hallway, however the door would be shut when care is provide to the patient for privacy.</p> <p>(B) Rooms 5 and 6 in the emergency department (ED) had water damage because when it rains, the water comes in that area.</p> <p>12. The manufacturer's recommendation</p>						

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	<p>for the McQuay Enfinity units specifies the units are to have preventive maintenance at least annually for a minimum requirement. The guidelines state on page 27: "1. Normal maintenance on all conditions is generally limited to filter changes.....2. Filter changes are required at regular intervals.....It is suggested that the filter be checked a t 60-day intervals for the first year until experience is acquired. If light cannot be seen through the filter when held up to sunlight or a bright light, it should be changed. A more critical standard may be desirable. 3. The condensate drain pan should be checked annually and cleaned and flushed as required. 4. Recording of performance measurements of volts, amps, and water temperature differences (both heating and cooling) is recommended. A comparison of logged date with start-up and other annual data is useful as an indicator of general equipment condition."</p> <p>13. Document provided by staff member #3 and titled "Air Conditioning/Heating Units" states "This is a current list of EH/Air Conditioning units that are not currently working: BHS Dining Room (sheet metal) BHS Room 316 BHS Room 317 (Bad Compressor)</p>			

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	<p>Med/Surg- Room 220 Med/Surg- Room 246 (Heat Only) Med/Surg- Room 211 Med/Surg- Room 230 Med/Surg- South Corridor ACU- Corridor unit</p> <p>CNO Office- Needs Contacts"</p> <p>14. Facility policy titled "ENVIRONMENT OF CARE PLAN" last reviewed/revised 2/14 states under purpose on page 1: "The hospital has a Environment of Care Plan that is designed to provide a physical environment free of hazards in which patient care is provided and staff activities managed to reduce the risk of human injury." Page 3 states "Through environmental tours of the building, risk assessments, grounds inspections and use of outside resources the hospital identifies issues and opportunities for improvement...." and "The Facilities Management department with the review and support of the Safety Committee has developed a buildings, grounds, and equipment policy and procedure to guide staff on the actions to take during the monthly grounds and equipment inspections."</p> <p>15. Facility policy titled "SAFETY MANAGEMENT PLAN" last</p>			

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S001160	<p>reviewed/revised 2/14 states on page 5: "The hospital maintains a safe environment.....The hospital conducts environmental tours to identify environmental deficiencies, hazards, and unsafe practices.....</p> <p>16. Facility policy titled "UTILITY SYSTEMS MANAGEMENT HVAC FAILURE" last reviewed/revised 10/10 states under policy on page 1: "St. Catherine Regional Hospital will take the necessary steps to correct any failures of essential equipment."</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained. Based on document review and staff interview, the facility failed to provide preventative maintenance to the McQuay Enfinity units throughout the hospital.</p> <p>Findings include;</p> <p>1. The manufacturer ' s recommendation for the</p>	S001160	<p>ISDH PLAN OF CORRECTION</p> <p>STATE TAG ID: S1160</p> <p>DATE DEFICIENCY WILL BE CORRECTED:</p> <p>3/17/2014</p>	04/17/2014

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S001172	<p>McQuay Enfinity units specifies the units are to have preventive maintenance at least annually for a minimum requirement. The guidelines state on page 27: "1. Normal maintenance on all conditions is generally limited to filter changes.....2. Filter changes are required at regular intervals.....It is suggested that the filter be checked a t 60-day intervals for the first year until experience is acquired. If light cannot be seen through the filter when held up to sunlight or a bright light, it should be changed. A more critical standard may be desirable. 3. The condensate drain pan should be checked annually and cleaned and flushed as required. 4. Recording of performance measurements of volts, amps, and water temperature differences (both heating and cooling) is recommended. A comparison of logged date with start-up and other annual data is useful as an indicator of general equipment condition."</p> <p>2. Staff member #3 indicated the following in interview beginning at 3:10 p.m. on 3/13/14: (A) He does not do PM on the McQuay Air Conditioning systems because there is no way to do it.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p>		<p>WHO IS RESPONSIBLE:</p> <p>DAVE MILLET (FACILITIES MANAGEMENT)</p> <p>WHAT IS THE PLAN OF CORRECTION:</p> <p>A PREVENTATIVE MAINTENANCE PROCEDURE ON MCQUAY UNITS</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN:</p> <p>3/17/2014</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p> <p>A PREVENTATIVE MAINTENANCE PROCEDURE ON MCQUAY UNITS WAS ESTABLISHED USING THE MANUFACTURER'S RECOMMENDATIONS FOR MAINTENANCE. THE PREVENTATIVE MAINTENANCE POLICY WILL BE REVIEWED AND/OR REVISED ANNUALLY AND A LOG OF THIS PREVENTATIVE MAINTENANCE WILL BE KEPT IN THE OFFICE OF THE FACILITIES DIRECTOR.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
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NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111
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	<p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, the facility failed to ensure patient dining areas were cleaned between meals for 1 patient dining area observed.</p> <p>Findings include;</p> <p>1. At time of tour on a.m. of 3/12/13, the activity/dining room had tables and chairs with food debris on them from breakfast and snack. The room was checked again at 11:56 on 3/12/14 when the patients were sitting at their tables waiting for lunch to be served and the tables and chairs still had the debris on them that had not been cleaned from breakfast.</p>	S001172	<p>ISDH PLAN OF CORRECTION</p> <p>STATE TAG ID: S1172</p> <p>DATE DEFICIENCY WILL BE CORRECTED: 04/21/2014</p> <p>WHO IS RESPONSIBLE: DAVE MILLET (FACILITIES DIRECTOR) GINGER OTTERSBAACH (CNO)</p> <p>WHAT IS THE PLAN OF CORRECTION:</p> <p>NURSING AND DIETARY STAFF EDUCATION REGARDING SAFE FOOD HANDLING AND SANITIZING AREAS WHERE FOOD IS CONSUMED BY THE PATIENTS</p> <p>WHEN THE PLAN OF CORRECTION WILL BEGIN:</p>	04/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER SAINT CATHERINE REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 MARKET ST CHARLESTOWN, IN 47111		
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			<p>04/16/2014</p> <p>HOW THE PLAN OF CORRECTION WILL OCCUR:</p> <p>DAVE MILLET (FACILITIES DIRECTOR) AND GINGER OTTERSBAUGH, CNO WILL EDUCATE STAFF ON THE SAFE AND PROPER PROCEDURE FOR FOOD HANDLING AND SANITIZING OF TABLES AND AREAS WHERE FOOD IS CONSUMED BY THE PATIENTS, INCLUDING BUT NOT LIMITED TO WEARING OF GLOVES WHEN HANDLING PATIENT FOOD AND PROPER HANDWASHING DURING FOOD HANDLING AND PREPARATION, AND THE USE OF SANITIZING WIPES TO CLEAN TABLES BETWEEN MEALS. THESE EMPLOYEES WILL SIGN DOCUMENTATION THAT THEY HAVE RECEIVED AND UNDERSTAND THIS EDUCATION AND THE SIGNATURES WILL BE KEPT IN THE OFFICE OF THE CNO AND FACILITIES DIRECTOR.</p> <p>POLICY AND PROCEDURES FOR FOOD HANDLING AND SANITIZING AREAS WHERE FOOD IS CONSUMED WILL BE INCLUDED IN EMPLOYEE ANNUAL SKILLS DAY CHECK OFF STATIONS AND DOCUMENTATION THAT ALL NURSING AND DIETARY STAFF HAS RECEIVED ANNUAL</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2014
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			<p>UPDATES ON THESE PROCEDURES WILL BE MAINTAINED WITH THE ANNUAL SKILLS DAY PACKET KEPT ON EACH STAFF MEMBER. SIGN IN SHEETS FOR ANNUAL SKILLS DAY WILL BE MAINTAINED AS DOCUMENTATION OF ATTENDANCE.</p>	