

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/02/2015
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S 0000  Bldg. 00	This visit was for a State hospital licensure survey.  Dates: 11/20/2015 to 12/2/2015  Facility Number: 005083  QA: cjl 12/16/15	S 0000	S 000 Preparation and/or execution of this Plan of Correction does not constitute an admission by St. Vincent Madison County Health System Inc. d.b.a.St. Vincent Mercy Hospital of the truth of facts alleged or conclusions setforth in the Statement of Deficiencies. We intend for the Plan of Correction to serve as St.Vincent Mercy's evidence of compliance.	
S 0332  Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)  (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:  (L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures. Based on document review and interview, the facility failed to ensure personnel files for environmental services (EVS) staff including documentation of training in effective housekeeping	S 0332	S 332 Who: The EVSmanager is responsible for ensuring that EVS personnel files include the appropriate documentation of training in effective housekeeping procedures. TheSurgery Nurse Manager is ultimately responsible	12/22/2015

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>procedures and competency for cleaning and disinfecting in the restricted operating room (OR) environment were maintained for 2 contracted EVS personnel (A10, A11).</p> <p>Findings:</p> <p>1. The Association of periOperative Registered Nurses (AORN) publication titled Recommended Practices for Environmental Cleaning (2014) indicated the following: VIII.a. Perioperative and environmental services personnel must receive education and complete competency verification activities that address specialized knowledge and skills related to the principles and processes of environmental cleaning ... IX.c. Policies and Procedures must include processes for initial education, training, ongoing competency verification, and annual review for issues related to environmental cleaning ... X.a. Process monitoring must be a part of every perioperative setting as part of an overall environmental cleaning program. Process monitoring should include ...cleaning procedures [and] monitoring cleaning and disinfection practices ...</p> <p>2. On 11-30-15 at 1520 hours, the contracted EVS manager, staff A9 was requested to provide a copy of the</p>		<p>for the corrective action andfor the overall and ongoing compliance secondary to her expertise and competency in the assigned responsibilities and verifying special procedures toensure that the perioperative environment is cleaned and disinfectedappropriately. <b>What:</b> Training materials and observation checklists for terminal cleaning in the perioperative environment were revised to address professional standards in order to protect patients and healthcare personnel from potentially infectious microorganisms. The cleaning tool kit utilized by the contracted service was updated and revised to include an organized procedure for performing terminal OR cleaning and toindicate the approved hospital-grade disinfectants and the wet contact time foruse in the OR. Personnel responsible for cleaning the perioperative environment received education and training on proper perioperative environmental cleaning and disinfection methods, agent use, and safety precautions. The checklist incorporated the appropriate use of high-level disinfectant, sequencing, cleaning path, wet surface contact times, and other items in accordance with the policy.Completed competency validation checklists were placed in the appropriate personnel files as documentation</p>	

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	<p>training documentation for the EVS staff providing services in the restricted surgical environment.</p> <p>3. On 11-30-15 at 1520 hours, the Environmental Cleaning Tool Kit (no contracted service name, effective date, or revision date) provided by the contracted services manager, staff A9, failed to indicate an organized procedure for performing terminal OR cleaning and failed to indicate the approved hospital-grade disinfectants or the minimum wet contact time for use in the OR.</p> <p>4. In interview on 12-01-15 at 1025 hours, the infection control nurse, staff A6, confirmed the EVS training documentation failed to indicate an organized procedure for performing terminal OR cleaning to prevent contamination of previously disinfected surfaces or indicate the approved hospital-grade disinfectants or the minimum wet contact time for use in the OR.</p> <p>5. Review of the personnel file for the primary contracted EVS OR cleaner, staff A10, failed to indicate evidence of training or documentation of competency in performing terminal OR cleaning or indicate the staff A10 had received or</p>		<p>of training and effective procedures and competency for cleaning and disinfecting in the restricted operating room environment. The surgery nurse manager will conduct random, quarterly observations to ensure ongoing compliance for the next year and bi-annually after that time period. <b>When:</b> Training materials and checklist were revised and updated by 12/15/2015. The EVS personnel training and observations were completed and competency documented in personnel files by 12/22/2015. <b>How:</b> The surgery nurse manager observed the perioperative terminal cleaning process using the checklist to validate the competence of the personnel.</p>		

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	<p>reviewed a copy of the Environmental Cleaning Tool Kit provided by the contracted services manager, staff A9.</p> <p>6. In interview on 12-02-15 at 1330 hours, the human resources coordinator, staff A18, confirmed the personnel file for the primary EVS OR cleaner, staff A10, failed to indicate documentation of training or competency in performing terminal OR cleaning.</p> <p>7. Review of the personnel file for the alternate EVS OR cleaner, staff A11, failed to indicate evidence of training or documentation of competency in performing terminal OR cleaning or indicate the staff A11 had received or reviewed a copy of the Environmental Cleaning Tool Kit.</p> <p>8. In interview on 12-02-15 at 1340 hours, the human resources coordinator, staff A18, confirmed the personnel file for the alternate EVS OR cleaner, staff A11, failed to indicate documentation of training or competency in performing terminal OR cleaning.</p> <p>9. In interview on 12-01-15 at 1415 hours, the director of surgical services, staff A8, confirmed they (A8) had not conducted any direct observations to validate the competency of the EVS staff</p>			

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S 0592 Bldg. 00	<p>while performing cleaning and disinfection services in the restricted OR environment.</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 and interview, the infection control (IC) committee failed to maintain its sanitation policy/procedures and ensure that the operating room (OR) cleaning and disinfecting was performed in a safe and effective manner.</p> <p>Findings:</p> <p>1. The Association of periOperative Nurses (AORN) Recommended Practices for Environmental Cleaning (2014) indicated the following: Cleaning and</p>	S 0592	S 592 <b>Who:</b> The Surgery Nurse Manager is ultimately responsible for the corrective action and for the overall and ongoing compliance secondary to her expertise and competency to ensure that the perioperative environment is cleaned and disinfected appropriately. <b>What:</b> The policy/procedure on <u>Infection Control in the OR</u> and the OR Terminal Cleaning Log were revised to delineate a methodical process for performing terminal cleaning in the OR to prevent contamination of previously disinfected surfaces, to specify	12/08/2015

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	<p>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 limit the transmission of microorganisms to reduce the risk of cross contamination of environmental surfaces... Clockwise or counter-clockwise cleaning may be performed when used in conjunction with clean-to-dirty and top-to-bottom methods ... All high touch objects, in addition to objects cleaned as part of routine cleaning, should be cleaned and disinfected ...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)...</p> <p>2. The policy/procedure Infection Control in the OR (approved 5-15) indicated the following: J. Operating Room Disinfection ...Terminal cleaning at the completion of the day's schedule as completed by environmental services ... Damp wiping overhead lights, light base, walls, general surfaces and vents ... The policy/procedure failed to indicate a methodical process for performing</p>		<p>the hospital-grade disinfectant to be used, to specify wet contact time for use in the OR and to designate all high-touch surfaces in the OR for cleaning. The terminal cleaning log incorporated cleaning objectives in an organized manner to avoid contaminating previously disinfected surfaces. <b>When:</b>The policy and the OR Terminal Cleaning log were revised and appropriate approvals obtained by 12/8/2015. <b>How:</b>Using reference materials from several expert sources (AORN, Association for the Healthcare Environment, CDC) the Surgery Nurse Manager and the Infection Control and Prevention Nurse revised the policy on <u>Infection Control in the OR</u> and the <u>OR Terminal Cleaning Log</u>. After appropriate review and approvals were obtained, the policy was used to guide the revisions of the training material and the checklist development.</p>	

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	<p>terminal OR cleaning to prevent contamination of previously disinfected surfaces, failed to indicate a specific hospital-grade disinfectant including wet contact time for use in the OR, and failed to indicate a provision for cleaning all high-touch surfaces in the OR.</p> <p>3. Review of the Infection Control in the OR policy attachment titled OR Terminal Cleaning Log (1-2008) indicated a list of objectives arranged in the following order: disinfect wipe the OR table ... [before] ...disinfect wipe the ceiling and lights. The cleaning log failed to list the OR cleaning objectives to complete in an organized manner to avoid the contamination of previously disinfected surfaces.</p> <p>4. On 12-01-15 at 0930 hours, the director of nursing, staff A2, and the infection control nurse, staff A6, confirmed that the policy/procedure failed to indicate a methodical process for OR cleaning that minimized the risk for contaminating previously disinfected surfaces.</p> <p>5. On 12-01-15 at 0935 hours, the director of nursing, staff A2, and the infection control nurse, staff A6, confirmed that the OR Terminal Cleaning Log failed to list the OR cleaning</p>			

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S 0872	<p>objectives in an organized manner to avoid contaminating previously disinfected surfaces.</p> <p>6. On 12-01-15 at 1425 hours, the director of surgical services, staff A8, confirmed that the OR Terminal Cleaning Log failed to list the OR cleaning objectives in an organized manner to avoid contaminating previously disinfected surfaces.</p> <p>7. In interview on 12-01-15 at 1615 hours, in the presence of the director of nursing, staff A2, the alternate EVS OR cleaner, staff A11, indicated they (A11) performed OR cleaning and disinfecting by applying the Virex disinfectant with a cleaning cloth for 30 seconds before wiping the surface off with a second cleaning cloth.</p> <p>8. On 12-01-15 at 1630 hours, the director of nursing, staff A2, confirmed the effective wet contact time of Virex was 10 minutes per manufacturer ' s recommendations and confirmed the terminal OR cleaning process described by EVS OR staff A11 failed to assure the OR cleaning and disinfecting was being performed in a safe or effective manner.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF</p>						

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Bldg. 00	<p>410 IAC 15-1.5-5(b)(3)(P)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(3) include, but not be limited to, the following:</p> <p>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on document review and interview, the facility failed to ensure that the final diagnosis was documented and the medical record (MR) completed within thirty (30) days following discharge for 5 of 16 MRs reviewed (patient #s 2, 3, 4, 14 &amp; 16).</p> <p>Findings:</p> <p>1. The Medical Staff Rules and Regulations (approved 5-15) indicated the following: At the time of discharge, the attending practitioner shall ensure the medical record is as complete as possible ...all entries shall be dated, timed, and authenticated by the author ...the records of discharged patients shall be completed within a period of time that will in no event exceed thirty (30) days following discharge.</p> <p>2. Review of patient #2's MR indicated</p>	S 0872	<p>S 872 <b>Who:</b> The Administrator is ultimately responsible for the corrective action and for overall and ongoing compliance. The Administrator may make a request for corrective action pursuant to the Bylaws of the Medical Staff or trigger an automatic suspension of privileges for any practitioner more than 14 days delinquent (incomplete medical records 30 days post discharge). <b>What:</b> The records identified in the deficiency were reviewed and it was determined that no negative patient outcomes occurred as a result of the deficiency. The President of the Medical Staff and the CNO reviewed the Medical Staff Bylaws on completion of medical records at the regularly scheduled meeting of the Medical Staff members in December. A notice was placed at each physician workstation reminding them to sign into <i>Sovera</i> (Medical Records) and complete their</p>	12/18/2015			

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	<p>the patient was discharged on 8-4-15 and the operative report was dictated on 9-11-15 and not authenticated by the surgeon until 10-29-15.</p> <p>3. On 12-2-15 at 1100 hours, the information technologist, staff A16, and the infection control nurse, staff A6, confirmed the MR for patient #2 was not completed in the required timeframe.</p> <p>4. Review of patient #3's MR indicated the surgery was performed and operative report was dictated on 8-10-15, the patient was discharged on 8-11-15, and the operative report was not authenticated by the surgeon until 9-16-15.</p> <p>5. On 12-2-15 at 1105 hours, the information technologist, staff A16, and the infection control nurse, staff A6, confirmed the MR for patient #3 was not completed in the required timeframe.</p> <p>6. Review of patient #4's MR indicated the patient was discharged on 9-14-15 and the operative report was dictated on 9-15-15 and not authenticated by the surgeon until 11-23-15.</p> <p>7. On 12-2-15 at 1110 hours, the information technologist, staff A16, and the infection control nurse, staff A6, confirmed the MR for patient #4 was not</p>		<p>medical records. One-on-one reminders were given to those practitioners with the highest delinquency rates. The medical records deficiency rate is back below 2%. Deficiency rates had spiked following a recent upgrade to Sovera which required a different log-in. This had been communicated to physicians prior to the upgrade and a reminder was sent to all physicians by HIM. <b>When:</b> The Medical Staff meeting was on 12/11/2015. The notice was posted at the practitioners' workstations on 12/4/2015. One-on-one communications with individual practitioners were completed by 12/18/2015. <b>How:</b> When a practitioner signs into Sovera (medical records), an automated process presents their incomplete medical records for completion. Monthly reports are sent to the administrator of the deficiency rates for review and any needed follow-up.</p>				

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S 0952 Bldg. 00	<p>completed in the required timeframe.</p> <p>8. Review of patient #14's MR indicated the patient died and death summary dictated on 3-21-15 and not authenticated by the physician until 4-27-15.</p> <p>9. On 12-2-15 at 1250 hours, the information technologist, staff A16, and the infection control nurse, staff A6, confirmed the MR for patient #14 was not completed in the required timeframe.</p> <p>10. Review of patient #16's MR indicated the patient was admitted on 7-04-15, the history and physical was dictated on 7-5-15, the patient was discharged on 7-7-15, and the history and physical was not authenticated by the attending physician until 8-13-15.</p> <p>11. On 12-2-15 at 1304 hours, the information technologist, staff A16, and the infection control nurse, staff A6, confirmed the MR for patient #16 was not completed in the required timeframe.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures.</p>						

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	<p>If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based upon document review and interview, the facility failed to assure that nursing staff maintained documentation of competency in blood product administration in accordance with its policy/procedure and accepted standards of practice for 6 of 8 nursing personnel files reviewed (N11, N12, N13, N15, N16 &amp; N17).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The policy/procedure Competency Assessment Program for the Nursing Staff (approved 5-15) indicated the following: Bi-annual skills fair shall be mandatory for all nursing service associates.</li> <li>2. Review of personnel files for Registered Nurse #s N11, N12, N13, N15, N16 and N17 failed to indicate annual documentation of blood administration competency in 2014 or 2015.</li> <li>3. During an interview on 12-02-15 at 1315 hours, the director of nursing, staff A2, confirmed the facility was not</li> </ol>	S 0952	<p><b>S 952 Who:</b> The Director of Nursing is ultimately responsible for the corrective action and for overall and ongoing compliance. <b>What:</b> The nursing service policy/procedure Competency Assessment Program was revised to require annual validation of blood administration competency rather than bi-annual. The annual nursing skills fair was scheduled prior to the survey for December - January. The education and competency validations for blood administration will be completed by January 15th. <b>When:</b> December 7th, 2015 – January 15th, 2016. <b>How:</b> Each modality of the skills fair has a trainer for the didactic portion, a pre- and post-test for the specific skill. A simulation manikin with demonstration of the skill is observed and checked –off to provide documented evidence of competence for the nurses file.</p>	01/15/2016

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S 1162 Bldg. 00	<p>conducting bi-annual skills fairs and confirmed the 6 nursing personnel files lacked documentation of blood administration competency for 2014 and 2015.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the hospital failed to ensure the automatic floor scrubber received preventive maintenance per the manufacturer's recommended maintenance schedule.</p> <p>Findings include:</p> <p>1. Review of Nilfisk Advance Automatic Floor Scrubber Instructions for Use indicated each battery should be checked weekly and the machine should be</p>	S 1162	S 1162 <b>Who:</b> The Maintenance Manager is responsible for the corrective action and for overall and ongoing compliance. <b>What:</b> The Maintenance Manager developed an operator's log for the floor scrubber to document weekly battery checks. The machine operator will check the battery and complete the log. If there are any problems with the battery, the machine operator will complete a work order and take the machine out of production until the work order is completed. The floor scrubber was already	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/02/2015	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
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S 1164  Bldg. 00	<p>lubricated monthly.</p> <p>2. Review of the preventive maintenance inspections of the hospital's automatic floor scrubber indicated it was only checked anually. The hospital failed to have any documented evidence that the floor scrubber was checked weekly or monthly as recomended by the manufacturer.</p> <p>3. In interview at 1:30 PM on 12/1/2015, staff member #5 (Maintenance Manager) confirmed all the above and no other documentation was provided prior to exit.</p>				<p>on the PMSchedule but the schedule was updated to incorporate monthly checks with lubrication as per the manufacturer's recommendations. <b>When:</b> The operator's log for weekly battery checks and the monthly lubrication schedule were fully implemented by 12/18/2015. <b>How:</b> When monthly lubrications are completed the maintenance personnel completing the lub job will check the weekly battery logs to ensure that the battery checks are being completed.</p>		
	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the</p>						

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	<p>safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and interview, the hospital failed to ensure the emergency power generator was tested every week per hospital policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of St. Vincent Mercy Hospital Life Safety Codes policy #188665 indicated the emergency power generator needs to be tested every week and load tested monthly. The policy last approved May 2013.</li> <li>Review of the preventive maintenance inspections of the hospital's emergency power generator indicated it was only load tested monthly and there was no evidence of weekly inspections: 1/30/15; 2/19/15; 3/27/15; 4/18/15; 5/31/15; 6/26/15; 7/23/15; 8/30/15; 9/24/15; 10/4/15; and 10/22/15.</li> <li>In interview at 1:30 PM on 12/1/2015, staff member #5 (Maintenance Manager) confirmed all the above and no other documentation was provided prior to exit.</li> </ol>	S 1164	<p>S 1164 <b>Who:</b> The Maintenance Manager is responsible for the corrective action and for overall and ongoing compliance. <b>What:</b> The Life Safety Code policy #188665 was revised to include a weekly emergency power generator test as well as a monthly load test. Testing logs used for documentation were updated to include a weekly test and a monthly load test. <b>When:</b> The monthly maintenance staff meeting was held December 21, 2015. <b>How:</b> Maintenance personnel reviewed the updated policy and generator testing logs at their monthly staff meeting in December.</p>	12/21/2015

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S 1172 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <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 document review, observation and interview, the facility failed to maintain a sanitary environment and ensure its restricted access sterile storage area was free of dust and particulate material for one occurrence.</p> <p>Findings:</p> <p>1. The policy/procedure Infection</p>	S 1172	<p>S 1172 <b>Who:</b> The Manager of Surgical Services is responsible for the corrective action and for overall and ongoing compliance. <b>What:</b> The dust and particulate material on the sloping top surfaces of the eight footwide wall cabinet and the top surfaces of the double boom light located directly over storage racks containing sterile wrapped instrument packages were</p>	01/22/2016

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	<p>Control in the OR (approved 5-15) indicated the following: sterile items are stored in clean, dry areas.</p> <p>2. During an observation on 12-01-15 at 1340 hours, in the presence of staff A8, the director of surgery services, the following was observed in the restricted surgery storage area room 1: a significant accumulation of dust and particulate material on the sloping top surfaces of an eight foot wide wall cabinet and on the top surfaces of a double boom light located directly over storage racks containing sterile wrapped instrument packages.</p> <p>3. During an interview on 12-01-15 at 1340 hours, staff A8, the director of surgery services, confirmed the presence of accumulated dust in the immediate vicinity of sterilized instrument packages and confirmed the storage area was unsanitary.</p>		<p>thoroughly cleaned. The cleaning of these surfaces was added to the cleaning checklist. A step stool was purchased to allow the EVS associates to reach the entire top surface of the wall cabinet. The double boom light located in the room currently used for storage will be removed.</p> <p><b>When:</b> The surfaces were cleaned appropriately on 12/3/2015, the checklist was updated on 12/15/2015, the double boom light will be removed by 1/22/2015. <b>How:</b> EVS personnel removed the dust and particulate material immediately at the time of the survey and then completed a terminal cleaning of both areas.</p>		