

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  01/09/2014
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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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 1/8/2014 through 1/9/2014</p> <p>Facility Number: 004975</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN PH Nurse Surveyor</p> <p>QA: claughlin 01/17/14</p>	S000000			

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 staff interview, the facility failed to ensure job/unit specific orientation for 4 (#N1, N4, N5 and N6) of 5 staff members.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Staff members #N1, N4, N5 and N6 personnel files lacked evidence of job/unit specific orientation.</li> <li>Staff member #31 verified the above at 5:20 p.m. on 1/9/14.</li> </ol>	S000308	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 308 DATE DEFICIENCY WILL BE CORRECTED: 2/10/2014 WHO IS RESPONSIBLE: DEPARTMENT MANAGERS AND DOUG LEE, MANAGER OF HUMAN RESOURCES WHAT IS THE PLAN OF CORRECTION: EACH DEPARTMENT WILL HAVE A DEPARTMENT SPECIFIC ORIENTATION CHECKLIST FOR NEW EMPLOYEES. WHEN THE PLAN OF CORRECTION WILL BEGIN: 2/10/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: EACH DEPARTMENT MANAGER WILL LOCATE AND UPDATE OR DEVELOP, AND IMPLEMENT A DEPARTMENT SPECIFIC ORIENTATION CHECKLIST TO BE DONE BY THE PRECEPTOR OF THE</p>	02/10/2014	

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			NEW EMPLOYEE CONTAINING SPECIFIC ELEMENTS OF PERFORMANCE IN THAT DEPARTMENT IN ORDER TO VALIDATE COMPETENCY IN THE POSITION. EACH ELEMENT OF PERFORMANCE TAUGHT DURING THIS ORIENTATION SHOULD BE SPECIFIC, AND INITIALED BY THE PRECEPTOR OF THE NEW EMPLOYEE UPON DEMONSTRATED COMPETENCY OF EACH ELEMENT, AND THE ENTIRE COMPLETED CHECKLIST SHOULD BE SIGNED BY THE EMPLOYEE RECEIVING THE TRAINING, THE PRECEPTOR, AND THE DEPARTMENT MANAGER. THE COMPLETED CHECKLIST WILL THEN BE FORWARDED TO THE MANAGER OF HUMAN RESOURCES TO BE FILED AND MAINTAINED IN THE EMPLOYEE FILE.		

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S000362	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review and interview, the facility failed to notify the organ procurement organization, per contract, of all hospital deaths for 2012 and 2013.</p>	S000362	ISDH PLAN OF CORRECTION STATE TAG ID: S 362 DATE DEFICIENCY WILL BE CORRECTED: 2/19/2014 WHO IS RESPONSIBLE: JEANNA	02/19/2014			

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the contract between the hospital and the Kentucky Organ Donor Affiliates (KODA) (last approved by the hospital on 5/20/2013) indicated the hospital shall provide Timely Referral to KODA as soon as possible of every individual whose death is imminent or who has died.</li> <li>2. Saint Catherine Regional Hospital Donation Activity 2012 indicated the hospital had 23 deaths and only 21 hospital deaths were reported to KODA. The 2013 monthly register was reviewed with reported deaths to KODA. The representatives for KODA identified the hospital reported 33 deaths; however, the 2013 monthly death register identified 35 hospital deaths.</li> <li>3. At 2:15 PM on 1/9/2014, staff member #3 indicated the 2012 number of hospital deaths reported to KODA were 2 short of the actual deaths that happened in the hospital. In 2013, the hospital reported 33 deaths, when actually there were 35 hospital deaths.</li> </ol>		<p>SCHROEDER, LPN (QUALITY), CAROL BLANKENBAKER (HIM) WHAT IS THE PLAN OF CORRECTION: AN ONSITE MEETING WITH C. ANN GITTINGS OF KODA TO DISCUSS PROCESS AND COMPLIANCE RATES FOR 2013, AND PROCESS FOR IMPROVEMENT FOR 2014, ALONG WITH A READ AND SIGN EDUCATIONAL INSERVICE FOR ALL RN AND LPN STAFF. WHEN THE PLAN OF CORRECTION WILL BEGIN: FEBRUARY 19, 2014 HOW THE PLAN OF CORRECTION WILL OCCUR: AN ONSITE MEETING ON FEBRUARY 4, 2014 BETWEEN C. ANN GITTINGS OF KODA, CAROL BLANKENBAKER (HIM), JEANNA SCHROEDER, LPN (QUALITY), AND KELLI BRASWELL, RN (ED DIRECTOR) TO DISCUSS DEATH REPORTING AND ORGAN/TISSUE PERFORMANCE DASHBOARD FOR 2013 AND REITERATE PROCESS FOR ORGAN AND TISSUE REFERRAL, ALONG WITH PROACTIVE METHODS FOR EDUCATION OF NURSING STAFF TO ENSURE THESE PROCESSES ARE FOLLOWED. THESE NURSING EDUCATION METHODS INCLUDE THE PRINTED PROCESSES FOR ORGAN AND TISSUE REFERRALS PER KODA. ALL</p>		

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			NURSES WILL READ THESE PROCESSES AT A NURSING COMMUNICATION MEETING AND SIGN TO VERIFY THAT THESE PROCESSES HAVE BEEN READ AND ARE UNDERSTOOD. THESE COLOR COPIES OF ORGAN AND TISSUE DONATION PROCESSES WILL ALSO BE LAMINATED AND PLACED ON EACH NURSES STATION BULLETIN BOARD FOR FUTURE REFERENCE.		

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure 13 services were part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Saint Catherine Regional Hospital's 2013 Performance Improvement Plan indicated all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</li> <li>Review of the facility's QA&amp;I program indicated it did not</li> </ol>	S000406	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 406 DATE DEFICIENCY WILL BE CORRECTED: 2/25/2014 WHO IS RESPONSIBLE: DEPARTMENT MANAGERS AND JEANNA SCHROEDER, LPN (QUALITY COORDINATOR) WHAT IS THE PLAN OF CORRECTION: EACH DEPARTMENT WILL BE REQUIRED TO ATTEND QUALITY COUNCIL MEETING AND REPORT ON QUALITY MEASURES PERTAINING TO EVERY ASPECT OF THEIR DEPARTMENT WHEN THE PLAN OF CORRECTION WILL BEGIN: 2/25/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: A DETAILED EMAIL WILL BE SENT TO EACH DEPARTMENT MANAGER EXPLAINING THE QUALITY MEASURES THAT MUST BE</p>	02/25/2014	

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	<p>include contracted services: Cardio Pulmonary Therapy, Central Sterile, Electroencephalography (EEG), Infusion Therapy, Outpatient Service, Pediatrics, Physical Therapy, Respiratory Care, Sleep Lab, Social Services, Speech Pathology, Utilization Review, and Behavioral Health Laundry Services.</p> <p>3. At 4:20 PM on 1/9/2014, staff member #4 indicated the 13 hospital services identified through Quality Review were not being monitored or evaluated as part of the hospital's comprehensive quality assessment and improvement (QA&amp;I) program.</p>		<p>MONITORED MONTHLY AND THAT MANDATORY MONITORING, ATTENDANCE AT QUALITY COUNCIL MEETING, AND MEASURE REPORTING WILL ENFORCED. ATTACHED TO THIS EMAIL WILL BE THE QUALITY MONITORING MODEL IN STOPLIGHT DASHBOARD FORMAT REFLECTING CURRENT COMPLIANCE OF THIS MODEL, AND HOW FUTURE COMPLIANCE WILL BE MANDATORY. QUALITY COORDINATOR WILL MAINTAIN COPIES OF MONTHLY REPORTING OF EACH DEPARTMENT IN THE QUALITY COUNCIL BINDER AND DOCUMENTATION WILL OCCUR IN THE QUALITY COUNCIL MONTHLY MINUTES, AS WELL. THESE MINUTES WILL THEN BE FORWARDED TO MEDICAL EXECUTIVE COMMITTEE.</p>		

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, the facility failed to ensure an environment that minimized risk to staff, patients or visitors for 1 medical surgical (med/surg) unit and 1 behavioral health unit (BHU).</p> <p>Findings include:</p> <p>1. During tour of the med/surg unit beginning at 11:00 a.m. on 1/9/14 and accompanied by staff member #1, the following expired items were found in the crash cart:</p> <p>(A) Two (2) 18 GA IV catheters with an expiration date of 10/13. (B) Two (2) 16 GA IV catheters with an expiration date of 10/13. (C) One (1) 24 GA IV catheter with an expiration date of 10/13. (D) Two (2) arterial blood sample kit with an expiration date of 10/13.</p> <p>2. During tour of the BHU beginning at 11:45 a.m. on 1/9/14 and accompanied by staff member #1 and staff member #N10, two (2) 16 GA IV catheters with an expiration date of 10/13 were found in</p>	S000554	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 554 DATE DEFICIENCY WILL BE CORRECTED: 2/13/2014 WHO IS RESPONSIBLE: GINGER OTTERSBAACH RN, CNO, KRISTA HALL, RN (EDUCATION, JEANNA SCHROEDER, LPN (IP), BRANDY GREEN, RN (BHS MANAGER) WHAT IS THE PLAN OF CORRECTION: REVIEWED/REVISED POLICY STATING THE POLICY FOR CHECKING CRASH CARTS AND RESPONSIBLE PERSON. NURSING EDUCATION DONE AT ANNUAL SKILLS DAY TO RE-EDUCATE NURSING STAFF REGARDING ISOLATION PRECAUTIONS AND PPE TO BE WORN. THE AVAILABILITY OF PPE IN ALL POSSIBLE LOCATIONS OF PATIENT HANDLING OR PATIENT PERSONAL ITEM HANDLING. A LAUNDRY SCHEDULE THAT ADDRESSES SEPARATE DAYS AND TIMES THAT EACH PATIENT'S PERSONAL CLOTHING WILL BE</p>	02/13/2014			

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	<p>the crash cart.</p> <p>3. Also during tour of the BHU, the following infection control issues were observed:</p> <p>(A) Staff member #N10 was observed handling soiled and potentially infectious clothing without gloves. After staff member #N10 indicated that each patient's laundry was laundered separately, staff member #N10 was asked who the soiled laundry belonged to that was in the washer. He/she reached into the washer without gloves on and went through several items of clothing to find the name on the clothing which revealed more than one patient name. Staff member #N10 later indicated that the unit had one (1) patient with an infection and that patient had MRSA in wounds on his/her legs (patient #9). Articles of laundry in the washer and handled by staff member #N10 without gloves belonged to patient #9.</p> <p>(B) Staff member #N10 continued on the tour unlocking doors and touching surfaces without washing his/her hands. After the tour was completed, he/she indicated they were going to wash their hands.</p> <p>(C) Additionally, a reddish/brown dried substance was noted on the side of a plastic hamper lid which was located in the hallway. When asked if the substance</p>		<p>LAUNDERED. WHEN THE PLAN OF CORRECTION WILL BEGIN: 02/13/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: REVIEW/REVISION TO CRASH CART POLICY ADDRESSING PROCEDURE FOR CHECKING CART SUPPLIES FOR EXPIRED ITEMS, INCLUDING WHEN THIS IS TO BE DONE, HOW OFTEN, PERSON(S) RESPONSIBLE, AND PROCEDURE FOR DOCUMENTING THAT THE CRASH CART SUPPLIES ARE CHECKED FOR EXPIRED ITEMS. READ AND SIGN NURSING EDUCATION WITH VISUALS, AND VERBAL DEMONSTRATION ON NURSING SKILLS DAY REGARDING TYPES OF ISOLATION PRECAUTIONS, AND REQUIRED PPE INCLUDING STANDARD PRECAUTIONS, CONTACT PRECAUTIONS, DROPLET PRECAUTIONS, AND AIRBORNE PRECAUTIONS. EACH DEPARTMENT MANAGER WILL ENSURE PPE IS AVAILABLE IN ALL AREAS OF PATIENT CARE AND AREAS WHERE PATIENT PERSONAL BELONGINGS COULD BE HANDLED BY STAFF, INCLUDING BUT NOT LIMITED TO IN HOUSE LAUNDRY AREA. A SET LAUNDRY SCHEDULE FOR WASHING EACH PATIENT'S PERSONAL</p>		

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	was blood, staff member #N10 took his/her bare finger and nail and rubbed/scraped the substance and said no. He/she did not wash hands after touching this unknown source.		LAUNDRY SEPARATELY.	

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S000602	<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, staff interview, and observation, the facility failed to follow the isolation precautions policy and failed to obtain orders related to positive culture for 1 (patient #9) of 1 patient on the behavioral health unit (BHU) with an infection.</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....."</p>	S000602	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 602 DATE DEFICIENCY WILL BE CORRECTED: 01/29/2014 WHO IS RESPONSIBLE: KRISTA HALL, RN (EDUCATION, JEANNA SCHROEDER, LPN (IP), BRANDY GREEN, RN (BHS MANAGER) WHAT IS THE PLAN OF CORRECTION: NURSING EDUCATION DONE AT ANNUAL SKILLS DAY TO RE-EDUCATE NURSING STAFF REGARDING ISOLATION PRECAUTIONS AND PPE TO BE WORN. THE AVAILABILITY OF PPE IN ALL POSSIBLE LOCATIONS OF PATIENT HANDLING OR PATIENT PERSONAL ITEM HANDLING. A LAUNDRY SCHEDULE THAT ADDRESSES SEPARATE DAYS AND TIMES THAT EACH PATIENT'S</p>	01/29/2014			

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	<p>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 and proper signage will be placed on the patient's door. Under standard precautions section, the document states "Soiled linen will be handled in such a way to avoid transfer microorganisms to other patients, personnel and environment. They will be placed in a leak proof bag....."</p> <p>2. Per medical record, patient #9 had positive bilateral leg wound cultures that were reported at 10:52 on 1/8/14. The cultures were positive for Methicillin resistant Staphylococcus aureus (MRSA).</p> <p>3. Staff member #N10 verified that patient #9 had MRSA at 12:00 p.m. on 1/9/14.</p> <p>4. Staff member #N11 indicated in interview at 12:10 p.m. on 1/9/14 that there were no specific wound care orders for patient #9.</p> <p>5. Staff member #20 indicated in interview at 12:45 p.m. on 1/9/14 that there were no patients on the unit on isolation precautions, therefore he/she was unaware of the positive culture and</p>		<p>PERSONAL CLOTHING WILL BE LAUNDERED. WHEN THE PLAN OF CORRECTION WILL BEGIN: 01/29/2013 HOW THE PLAN OF CORRECTION WILL OCCUR: READ AND SIGN NURSING EDUCATION WITH VISUALS, AND VERBAL DEMONSTRATION ON NURSING SKILLS DAY REGARDING TYPES OF ISOLATION PRECAUTIONS, AND REQUIRED PPE INCLUDING STANDARD PRECAUTIONS, CONTACT PRECAUTIONS, DROPLET PRECAUTIONS, AND AIRBORNE PRECAUTIONS. EACH DEPARTMENT MANAGER WILL ENSURE PPE IS AVAILABLE IN ALL AREAS OF PATIENT CARE AND AREAS WHERE PATIENT PERSONAL BELONGINGS COULD BE HANDLED BY STAFF, INCLUDING BUT NOT LIMITED TO IN HOUSE LAUNDRY AREA. A SET LAUNDRY SCHEDULE FOR WASHING EACH PATIENT'S PERSONAL LAUNDRY SEPARATELY.</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  01/09/2014
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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>need for isolation for patient #9.</p> <p>6. During tour of the unit which began at 11:45 a.m. on 1/9/14, the following observations were made:</p> <p>(A) Patient #9 was observed in the common dining room with other patients and then in the hallway sitting in his/her wheelchair across from the nurse station.</p> <p>(B) There was no signage for isolation for patient #9.</p> <p>(C) Patient #9's laundry was mixed with other patients' laundry in a common washer.</p>			

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S000606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on document review and staff interview, the hospital failed to monitor information about health and activities as they relate to diseases that are transmissible through food for 2 (#6 and #12) of 4 kitchen staff workers, failed to monitor the immune status for the contracted kitchen staff member #6 for Rubella, Rubeolla and Varicella and failed to determine the disease history/immunity to Rubeola for 4 (#N1, N4, N5, and N6) of 5 staff members.</p>	S000606	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 606 DATE DEFICIENCY WILL BE CORRECTED: 01/24/2014 WHO IS RESPONSIBLE: KELLI BRASWELL, RN (ER MANAGER, EMPLOYEE HEALTH), DOUG LEE (HUMAN RESOURCES DIRECTOR) WHAT IS THE PLAN OF CORRECTION: ALL EMPLOYEES WILL HAVE EVIDENCE OF DISEASE HISTORY/IMMUNITY TO RUBELLA, RUBEOLLA, AND VARICELLA WHEN THE PLAN OF CORRECTION WILL BEGIN: 01/24/2013 HOW THE PLAN OF CORRECTION WILL OCCUR: ALL EMPLOYEE FILES</p>	01/24/2014			

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	<p><b>Findings:</b></p> <p>1. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food."</p> <p>2. On 1/9/2014, two of four kitchen staff member (#6 and #12) personnel records provided did not identify that the foodservice staff were provided information on how to report diseases that are transmittable through food.</p> <p>3. Contracted staff member #6 health care record provided did not identify the staff member was screened for Rubella, Rubeolla, and Varicella.</p>		<p>WERE SCREENED FOR EVIDENCE OF HISTORY/IMMUNITY OF RUBELLA, RUBEOLLA AND VARICELLA AND THOSE DEEMED WITH NO EVIDENCE WILL HAVE THESE TITERS DRAWN AND SENT TO A CONTRACTED OUTSIDE LAB. INCLUSION OF THESE TITERS WILL BE PLACED ON A NEW EMPLOYEE HIRING PROCEDURE CHECKLIST AND PLACED ON THE EMPLOYEE FILE TO ENSURE THAT SCREENING FOR THESE DISEASES IS DONE UPON HIRE.</p>		

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S000606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>4. Staff members #N1, N4, N5, and N6 personnel files lacked evidence of disease history/immunity to Rubeola.</p> <p>5. Staff member #31 verified the above at 5:20 p.m. on 1/9/14.</p>	S000606	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 606 DATE DEFICIENCY WILL BE CORRECTED: 01/24/2014 WHO IS RESPONSIBLE: KELLI BRASWELL, RN (ER MANAGER, EMPLOYEE HEALTH), DOUG LEE (HUMAN RESOURCES DIRECTOR) WHAT IS THE PLAN OF CORRECTION: ALL EMPLOYEES WILL HAVE EVIDENCE OF DISEASE HISTORY/IMMUNITY TO RUBELLA, RUBEOLLA, AND VARICELLA WHEN THE PLAN OF CORRECTION WILL BEGIN: 01/24/2013 HOW THE PLAN OF CORRECTION WILL OCCUR: ALL EMPLOYEE FILES</p>	01/24/2014

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			WERE SCREENED FOR EVIDENCE OF HISTORY/IMMUNITY OF RUBELLA, RUBEOLLA AND VARICELLA AND THOSE DEEMED WITH NO EVIDENCE WILL HAVE THESE TITERS DRAWN AND SENT TO A CONTRACTED OUTSIDE LAB. INCLUSION OF THESE TITERS WILL BE PLACED ON A NEW EMPLOYEE HIRING PROCEDURE CHECKLIST AND PLACED ON THE EMPLOYEE FILE TO ENSURE THAT SCREENING FOR THESE DISEASES IS DONE UPON HIRE.	

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S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on document review and observation, the facility failed to enforce the dress code policy on 1 behavioral health unit (BHU).</p> <p>Findings include:</p> <p>1. Facility policy titled "Dress Code-Uniforms &amp; Personal Appearance" last reviewed/revised 4/23/13 states on page 3 of 5 under "GENERAL APPEARANCE (for all employees)": "Rings or earrings in non-conventional places (i.e. nose, eyebrows.....) will not be allowed in any area of the hospital.</p> <p>2. During tour of BHU beginning at 11:45 a.m. on 1/9/14, staff member #21</p>	S000608	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 608 DATE DEFICIENCY WILL BE CORRECTED: 02/24/2014 WHO IS RESPONSIBLE: ALL DEPARTMENT MANAGERS WHAT IS THE PLAN OF CORRECTION: REVIEW OF DRESS CODE POLICY WITH ALL EMPLOYESS WITH EMPLOYEE SIGNATURE TO VERIFY REVIEW AND UNDERSTANDING WHEN THE PLAN OF CORRECTION WILL BEGIN: 02/24/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: ALL DEPARTMENT MANAGERS WILL BE GIVEN A COPY OF THE DRESS CODE POLICY TO REITERATE AND</p>	02/24/2014
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	was observed with a nasal piercing.		ALLOW THEIR EMPLOYEES TO READ. ALL EMPLOYEES WILL READ THIS POLICY AS DISTRIBUTED BY THEIR DEPARTMENT MANAGER AND SIGN IN AGREEMENT THAT IT HAS BEEN READ, UNDERSTOOD, AND WILL BE ENFORCED. ALL EMPLOYEES WILL ALSO SIGN IN UNDERSTANDING THAT NOT FOLLOWING THIS POLICY COULD RESULT IN DISCIPLINARY ACTION.		

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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 documentation review, observation and staff interview, the facility failed to ensure the Behavioral Health Laundry services was utilizing a chemical detergent registered with EPA for use as a hospital disinfectant or another effective means for properly disinfecting patient laundry and failed to properly handle soiled patient laundry before it was washed and dried.</p> <p>Findings included:</p> <p>1. CDC guidelines for laundry</p>	S000612	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 612 DATE DEFICIENCY WILL BE CORRECTED: 03/05/2014 WHO IS RESPONSIBLE: GINGER OTTERSBAACH, RN, CNO AND BRANDY GREEN, RN BHS MANAGER, JEANNA SCHROEDER, LPN (INFECTION CONTROL) WHAT IS THE PLAN OF CORRECTION: RE-INSTATED BEHAVIORAL HEALTH SERVICES LAUNDERING PROCESS POLICY AND DOCUMENTATION LOG WHEN THE PLAN OF CORRECTION WILL BEGIN: 03/05/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: BEHAVIORAL HEALTH UNIT LAUNDERING POLICY WILL DEFINE POLICY</p>	02/18/2014
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	<p>services in health care facilities states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled at a residual of 50-150 ppm during the chlorine bleach cycle."</p> <p>2. At 2:30 PM on 1/8/2013, the Behavioral Health Laundry room was toured. Assorted patient laundry items were stored on the floor next to the washer. The room only contained a partial case of a 50 LB box of Tough Guy Laundry Detergent.</p>		<p>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 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 CLOTHINGTHIS POLICY WAS DEVELOPED AND APPROVED BY INFECTION</p>	

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	<p>3. Behavioral Health Services Laundry Room policy (Last approved April 23rd, 2013) states, "Follow manufacturer's instructions on detergent to clean patient clothing properly."</p> <p>4. Tough Guy Laundry Detergent directions for use do not specify how to use the product in the washing machine for properly disinfecting the patient clothes. Tough Guy detergent chemical detergent was not registered with EPA for use as a hospital disinfectant. Behavioral Health staff washed the patient clothes in Tough Guy and did not use any other effective means for properly disinfecting patient laundry.</p> <p>5. The Estate Whirlpool Washer user instructions indicated to measure and pour into the washer: Add powder or liquid color safe bleach. The washer user instruction specify bleach to be used for disinfectant.</p>		<p>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 AND DISINFECTING OF THE WASHER BETWEEN EACH LOAD. THE RESULTS OF THIS MONITORING WILL BE REPORTED TO INFECTION CONTROL COMMITTEE MONTHLY TO EVALUATE METHOD, COMPLIANCE, AND FOR NECESSARY POLICY REVISIONS.</p>				

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	6. At 11:36 AM on 1/9/2014, staff member #12 indicated only 120 degree Fahrenheit of water is pumped into the Behavioral Health washer. Staff are required to add bleach into a later washing cycle, however, the Behavioral staff are not doing that. The staff member confirmed the laundry room does not have bleach in the room. The staff member confirmed the powder detergent the staff are using does not specify that it was for a health care setting. The staff member indicated he/she does not know the hot temperature the dryer meets. The staff member indicated the washer and dryer are not being monitored or evaluated if they are meeting the CDC guidelines for washing patient clothing in a healthcare setting. The staff member indicated the loose patient laundry that was observed stored on the floor next to the washer was not the correct procedure on proper handling of patient laundry. The Behavioral Health staff wash and						

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	dry all patient laundry. Occasionally, patient family will take their family member's laundry home to wash.			
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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.</p> <p>7. Interview with the infection control nurse beginning at 1:00 p.m. on 1/8/14 indicated that he/she was unaware of any in-house laundry services provided by the facility.</p> <p>8. Staff member #20 indicated the following in interview beginning at 12:45 p.m. on 1/9/14: (A) There were no specific requirements for laundry on the unit. He/she indicated you could use hot or warm water and he/she used warm.</p>	S000612	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 612 DATE DEFICIENCY WILL BE CORRECTED: 03/05/2014 WHO IS RESPONSIBLE: GINGER OTTERSBAUGH, RN, CNO AND BRANDY GREEN, RN BHS MANAGER, JEANNA SCHROEDER, LPN (INFECTION CONTROL) WHAT IS THE PLAN OF CORRECTION: RE-INSTATED BEHAVIORAL HEALTH SERVICES LAUNDERING PROCESS POLICY AND DOCUMENTATION LOG WHEN THE PLAN OF CORRECTION WILL BEGIN: 03/05/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: BEHAVIORAL HEALTH UNIT LAUNDERING POLICY WILL DEFINE POLICY</p>	02/18/2014			

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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>9. During tour of the behavioral health unit beginning at 11:45 a.m. on 1/9/14 and accompanied by staff members #1 and #N10, the following was observed:</p> <p>(A) The unit has a washer and dryer utilized for patient personal laundry.</p> <p>(B) Staff member #N10 indicated that the laundry was sorted and each patient's laundry is washed individually, however when asked who the laundry belonged to that was in the washer at the time of the tour, it was found that different articles of patients' laundry were in the washer.</p> <p>(C) Staff member #10 did not wear gloves to handle the soiled laundry in the laundry room which included laundry belonging to a patient with MRSA.</p> <p>(D) The laundry room contained a large box of powder detergent. Per label instructions, the detergent has no disinfectant properties.</p> <p>(E) There was no bleach or other disinfecting agents within the laundry area.</p>		<p>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 MANUFACTURER'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 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</p>		

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	10. Facility policy titled "LAUNDRY ROOM" last reviewed/revised 4/23/13 lacks directions including, but not limited to, glove use when handling soiled linens, handling isolation laundry, appropriate water temperatures or use of disinfectant agents. The policy basically states the clothing is washed by following "manufacturers instructions" on the detergent, dried, folded and put away.		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 AND DISINFECTING OF THE WASHER BETWEEN EACH LOAD. THE RESULTS OF THIS MONITORING WILL BE REPORTED TO INFECTION CONTROL COMMITTEE MONTHLY TO EVALUATE METHOD, COMPLIANCE, AND FOR NECESSARY POLICY REVISIONS.	
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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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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.</p> <p>Based on staff interview and observation, a registered nurse failed to ensure patients could independently remove lap belts ensuring that the belt was not a restraint for 1 behavioral health unit (BHU) toured.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Staff member #N12 indicated the following in interview at 12:00 p.m. on 1/9/14: (A) The unit has a census of eighteen (18) patients and "probably fourteen (14) to fifteen (15)" of the patients have a lap belt secured around their waist. (B) The lap belts do not require an order.</li> <li>Staff member #20 indicated in interview beginning at 12:30 p.m. on 1/9/14 that he/she has never observed patient #16 or #17 remove their lap belt.</li> <li>Staff member #N10 indicated in interview at 12:25 p.m. on 1/9/14 that there was no documentation that the</li> </ol>	S000930	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 930 DATE DEFICIENCY WILL BE CORRECTED: 02/14/2014 WHO IS RESPONSIBLE: BRANDY GREEN, RN, BHS MANAGER WHAT IS THE PLAN OF CORRECTION: DISCONTINUED USE OF BUCKLING LAP BELTS ON BEHAVIORAL UNIT PATIENTS. WHEN THE PLAN OF CORRECTION WILL BEGIN: 02/14/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: ALL BUCKLING RELEASE TYPE LAP BELTS WILL BE REMOVED FROM THE BEHAVIORAL UNIT AND INDEPENDENT RELEASE VELCRO LAP BELTS WILL BE USED.</p>	02/14/2014			

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	<p>patients could independently remove their lap belts.</p> <p>4. During observation at lunch on 1/9/14, the following was observed:</p> <p>(A) Lap belts were observed on multiple patients. The lap belts had a buckle type release that would require pushing in 2 areas of the buckle to allow it to release.</p> <p>(B) Patient #16 was being fed by staff. He/she attempted to feed self, however was unable to securely grasp a sandwich enough to eat and had a severe tremor.</p> <p>(C) Patient #17 was being fed by staff. He/she appeared to be flaccid on the left side (history of a previous stroke). He/she used his/her right hand only to secure a cup to drink.</p> <p>(D) The above patients did not appear to be able to unbuckle a lap belt independently, therefore making the lap belt a restraint.</p>				

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S000932	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. Based on document review and staff interview, the nursing staff failed to develop completed care plans for 3 (patients #12, 13, and 15) of 7 patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Care plans were developed for patients #12, 13, and 15, however there were no interventions listed to achieve care plan goals for each of the patients.</li> <li>Staff member #5 verified the above at 3:30 p.m. on 1/9/14.</li> </ol>	S000932	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 932 DATE DEFICIENCY WILL BE CORRECTED: 02/19/2014 WHO IS RESPONSIBLE: KRISTA HALL, RN (EMR SYSTEM PROJECT COORDINATOR, NURSING EDUCATION) WHAT IS THE PLAN OF CORRECTION: ALL NURSING STAFF WILL ATTEND A MANDATORY EDUCATION/UPDATE ON PATIENT CARE PLANS IN THE ELETRONIC MEDICAL RECORD SYSTEM. WHEN THE PLAN OF CORRECTION WILL BEGIN: 02/19/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: ALL NURSING STAFF WILL ATTEND A MANDATORY ELECTRONIC MEDICAL RECORD EDUCATION/UPDATE. THE AGENDA WILL INCLUDE A SESSION ON CREATING A CARE PLAN WITH PROBLEMS, GOALS AND INTERVENTIONS AND NURSING STAFF WILL BE MADE AWARE THAT A CARE PLAN IS A REQUIREMENT FOR</p>	02/19/2014	

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			ALL PATIENTS.	

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S000948	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(5)</p> <p>(c) Drugs and biologicals shall be prepared for administration and administered as follows:</p> <p>(5) In accordance with currently acceptable standards of practice. Based on observation, staff interview, and document review, the facility failed to ensure IV flush solutions were administered according to acceptable standards of practice for 1 emergency department (ED).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During tour of the ED beginning at 10:40 a.m. on 1/9/14, a bag of .9% Sodium Chloride IV solution was observed hanging from a cabinet in a treatment room. The bag was labeled with the date of 1/9/14 and time of 0605.</li> <li>2. Staff member #1 indicated the solution is used for IV flushes and is changed out every 24 hours.</li> <li>3. Document titled "APIC position paper: Safe injection, infusion, and medication vial practices in health care" states on page 169 under IV SOLUTIONS: "Never use IV solution containers (eg. bags, bottles) to obtain</li> </ol>	S000948	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 948 DATE DEFICIENCY WILL BE CORRECTED: 01/13/2014 WHO IS RESPONSIBLE: GINGER OTTERSBAACH, CNO, DAVE MILLET, MATERIALS MANAGEMENT, BRANDY GREEN, RN, NURSE MANAGER WHAT IS THE PLAN OF CORRECTION: PREFILLED, INDIVIDUAL USE NORMAL SALINE FLUSH SYRINGES WHEN THE PLAN OF CORRECTION WILL BEGIN: 01/13/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: PREFILLED, INDIVIDUAL USE NORMAL SALINE SYRINGES WERE ORDERD AND RECEIVED FOR IV FLUSH USE. MULTI USE BAGS OF .9% SODIUM CHLORIDE WILL NOT BE USED TO DRAW SALINE FOR FLUSH.</p>	01/13/2014	

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	flush solutions or for any other purpose for more than 1 patient."			

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S000952	<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. 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 on document review and staff interview, the facility failed to ensure documentation that registered nurses (RN) were trained in blood transfusions for 1 newly hired RN.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Staff member #N6 (RN) was hired 7/13 and his/her personnel file lacked evidence that he/she was trained in blood transfusions.</li> <li>Staff member #31 verified the above at 5:20 p.m. on 1/9/14.</li> </ol>	S000952	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 952 DATE DEFICIENCY WILL BE CORRECTED: 01/29/2014 WHO IS RESPONSIBLE: KRISTA HALL, RN (EMR SYSTEM PROJECT COORDINATOR, NURSING EDUCATION), CLARK DANIELS (LAB DIRECTOR) WHAT IS THE PLAN OF CORRECTION: DEPARTMENT SPECIFIC NURSING UNIT ORIENTATIONS AND ANNUAL SKILLS COMPETENCY TRAINING DAY. WHEN THE PLAN OF CORRECTION WILL BEGIN: 01/29/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: ALL NURSING STAFF WILL BE GIVEN A DEPARTMENT SPECIFIC ORIENTATION WHICH WILL INCLUDE BLOOD PRODUCT ADMINISTRATION AND PROPER DOCUMENTATION OF BLOOD ADMINISTRATION. THIS TRAINING WILL BE</p>	01/29/2014			

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			DOCUMENTED ON THE DEPARTMENT SPECIFIC ORIENTATION CHECKLIST FOR EACH NURSING UNIT. EACH NURSE WILL ALSO ATTEND A MANDATORY ANNUAL SKILLS COMPETENCY DAY TO ENSURE PROFICIENCY IN ALL NURSING SKILLS COMPETENCIES. THIS SKILLS COMPETENCY DAY WILL INCLUDE BLOOD ADMINISTRATION PROFICIENCY TRAINING, AND DOCUMENTATION OF ALL NURSES ATTENDING WILL BE MAINTAINED IN NURSING EDUCATION FILES. PROPER DOCUMENTATION OF BLOOD ADMINISTRATION WILL ALSO BE MAINTAINED AS A QUALITY IMPROVEMENT MONITOR WITH A BLOOD ADMINISTRATION CHECKLIST THAT IS DONE IN BLOOD BANK WITH THE BLOOD TRANSFUSION RECORD SHEET. THESE WILL BE CHECKED FOR PROPER DOCUMENTATION AND QUALITY IMPROVEMENT MONITORING WILL BE DONE BY THE LAB DIRECTOR.	

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S001118	<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 and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in five (5) instances.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. General Department Safety Policy (Last approved April 23rd, 2013) indicated that each department shall maintain their department safe and sanitary to provide physical safety of patients, visitors, and employees.</li> <li>2. Compressed Gas and Oxygen</li> </ol>	S001118	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 1118 DATE DEFICIENCY WILL BE CORRECTED: 01/21/2014 WHO IS RESPONSIBLE: DAVE MILLET, FACILITIES MANAGER WHAT IS THE PLAN OF CORRECTION: CO2 TANKS WILL BE SECURED, EYE WASH STATION WILL NOT BE OBSTRUCTED, ACETYLENE TANK WILL BE SECURED, FIRE HYDRANTS WILL BE RELOCATED AND SECURED, ELECTRICAL ROOM WILL BE FREE OF CLUTTER AND COMBUSTIBLE ITEMS WILL NOT BE IN DIRECT CONTACT WITH HIGH VOLTAGE ELECTRICAL PANELS, AND HANIDCAP DOORS WILL HAVE INTACT PUSH PLATES AND BE OPERATIONAL ORDER. WHEN THE PLAN OF CORRECTION WILL BEGIN: 01/21/2014 HOW THE PLAN OF CORRECTION</p>	01/21/2014			

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	<p>Use (Last approved April 23rd, 2013) states, "Cylinders must be secured at all times so they cannot fail."</p> <p>3. At 1:15 PM on 1/8/14, the Dietary Department Dry Storage room was inspected. The room had two CO2 tanks unsecured. The chain was observed hanging next to both tanks.</p> <p>4. At 2:00 PM on 1/8/2014, the Cardio Pulmonary room was toured. The wall mounted eye-wash station was observed obstructed by a portable ventilator and two other pieces of equipment.</p> <p>5. At 2:15 PM on 1/8/2014, the Ground Floor Maintenance Room was inspected. An acetylene tank was observed unsecured. Seven fire hydrants were observed on the maintenance table tops next to the edge of the tops and were observed not secured.</p> <p>6. At 2:30 PM on 1/8/2014, the</p>		<p>WILL OCCUR: IN THE DIETARY DEPARTMENT, CO2 TANKS WERE SECURED BY RESTRAINT CHAINS CLIPPED TO A WALL ANCHOR. EQUIPMENT WAS MOVED FROM THE CARDIO PULMONARY ROOM TO ENSURE PATH TO EYE WASH STATION IS NOT OBSTRUCTED. ACETYLENE TANK IN THE GROUND FLOOR MAINTENANCE ROOM WAS INSTALLED INTO A RESTRAINT DEVICE TO SECURE IT. FIRE HYDRANTS WERE RELOCATED FROM THE TABLE TOPS TO A LOCATION WHERE CHAIN TYPE RESTRAINTS WERE APPLIED TO THEM TO SECURE THEM AND PREVENT THEM FROM FALLING. CLUTTER, INCLUDING COMBUSTIBLE ITEMS WERE REMOVED FROM THE MAIN ELECTRICAL ROOM AND RELOCATED TO AN APPROVED STORAGE ROOM. PUSH PLATES WERE INSTALLED TO MAIN ENTRANCE HANDICAP DOORS AND THESE DOORS WERE ENSURED TO BE IN OPERATIONAL ORDER. ALL OF THESE ITEMS WILL BE INCLUDED IN DAILY MAINTENANCE ROUNDS AND WILL BE VISUALLY INSPECTED FOR CONTINUED COMPLIANCE, AND MAIN ENTRANCE HADICAP DOORS WILL BE TESTED DURING</p>		

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	<p>Main Electrical room was observed heavily cluttered with assorted equipment, supplies, and boxes. Combustible items were observed stored in direct contact with high voltage electrical panels.</p> <p>7. At 4:00 PM on 1/8/2014, the Main Entrance handicap doors were not operational. The handicap push button was missing on the outside of the handicap Main Entrance doors.</p>		<p>THESE ROUNDS TO ENSURE THAT PUSH PLATES CONTINUE TO BE INTACT AND IN WORKING ORDER.</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			
(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			
S001172	<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 observation, staff interview, and document review, the facility failed to ensure housekeeping staff used germicidal solution to clean patient bathrooms and failed to maintain an environment that could be appropriately cleaned in one medical surgical unit toured.</p> <p>Findings include:</p> <p>1. During tour of the medical surgical unit beginning at 11:00 a.m. on 1/9/14 and accompanied by staff member #1, the following was observed:</p> <p>(A) In the patient nutrition pantry, a hot water faucet was visible adjacent to the</p>	S001172	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 1172 DATE DEFICIENCY WILL BE CORRECTED: 02/14/2014 WHO IS RESPONSIBLE: DAVE MILLET, DIRECTOR OF FACILITIES WHAT IS THE PLAN OF CORRECTION: HOT WATER FAUCET IN CLEAN UTILITY ROOM ON MED/SURG UNIT REMOVED. RE-EDUCATE HOUSEKEEPING STAFF ON CLEANING POLICY AND PROPER USE OF HOSPITAL CLEANING CHEMICALS WHEN THE PLAN OF CORRECTION WILL BEGIN: 02/14/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: NON FUNCTIONING HOT WATER</p>	02/14/2014			

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  01/09/2014
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>sink. The faucet was covered with loose fitting duck tape, therefore the area could not be appropriately cleaned/disinfected.</p> <p>2. Staff member #1 indicated at the time of the above observation that the faucet was for very hot water and it no longer worked.</p> <p>3. Housekeeper #1 indicated in interview at the time of the tour that he/she uses the CREW tub/tile cleaner to clean the patients' bathrooms. Per housekeeper #1, the solution is used on the shower, sink and commode.</p> <p>4. Review of label contents for the solution the housekeeper was referring to indicated the solution is not a disinfectant product.</p> <p>5. Facility policy titled "CLEANING RESTROOMS" last reviewed/revised 1/12 indicates under equipment needed that germicidal solution is needed. The policy indicates under procedure that the sink, commode and showers are to be cleaned with a germicidal solution.</p>		<p>FAUCET IN CLEAN UTILITY ROOM ON MED/SURG UNIT WAS REMOVED. DAVE MILLET, DIRECTOR OF FACILITIES RE-EDUCATED HOUSEKEEPING STAFF USING A READ AND SIGN INSERVICE METHOD ON THE PROPER CLEANING TECHNIQUES, CLEANING POLICY, AND PROPER USE OF HOSPITAL CLEANING CHEMICALS</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  01/09/2014
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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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S001197	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and staff interview, the facility failed to ensure the hospital had an annual fire safety inspection by the local fire control agencies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The Fire Safety Management Plan (Last approved April 23rd, 2013) indicated the hospital was to have routine fire/safety inspections of the hospital by an outside regulatory agency.</li> <li>The Division of Fire and Building Safety; Indiana Department of Homeland Security last Fire and Code Enforcement Compliance inspection was 3/23/2010.</li> <li>At 3:15 PM on 1/8/2014, staff member #12 indicated the facility has not contacted their local fire chief nor the State Fire Marshall to inspect their</li> </ol>	S001197	<p>ISDH PLAN OF CORRECTION STATE TAG ID: S 1197 DATE DEFICIENCY WILL BE CORRECTED: 02/25/2014 WHO IS RESPONSIBLE: DAVE MILLET, DIRECTOR OF FACILITIES WHAT IS THE PLAN OF CORRECTION: LIFE SAFETY INSPECTION TO OCCUR ONSITE WHEN THE PLAN OF CORRECTION WILL BEGIN: 02/17/2014 HOW THE PLAN OF CORRECTION WILL OCCUR: DAVE MILLET WILL CONTACT AND ACCOMPANY CHARLESTOWN FIRE CHIEF FOR AN ONSITE VISIT TO INSPECT FOR LIFE SAFETY ISSUES WITHIN THE FACILITY</p>	02/25/2014

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 01/09/2014
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	facility for fire safety.			