

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2016
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NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260
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S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 005075 Survey Date: 05-16-2016 - 05-19-2016 QA: 06-30-16 CL IDR Committee held on 07-27-16. Tag S0312 modified. JL	S 0000		
S 0102 Bldg. 00	410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a) (a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on document review and interview, the facility failed to follow IC (Indiana Code) regarding a check of the nurse aide registry for 2 of 2 patient care techs whose files were reviewed, staff members N15 and N17. Findings Include: 1. Review of IC 16-28-13-4, reads in Sec. 4. (a): Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or	S 0102	S102 Facility failed to follow Indiana Code regarding a check of the nurses' aide registry for two patient care techs. Corrective Action(s): On or before July 8, 2016, the Talent Acquisition Management Business Rules were reviewed and revised to include that all associates within 3 business days from date of employment as an unlicensed employee will have a copy of the person's state nurse aid registry report from the state department to ensure they are safe to provide	07/08/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>(2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a healthcare facility; shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of the policy Employment Process, policy number 1001758, last revised 9/2014, indicated under Policy: "...St. Vincent Indianapolis Hospitals strictly adhere to all State/Federal legal requirements pertinent to the employment process..."</p> <p>3. Review of the job description for Technician-Pat (patient) Care Admin, job code 700360, with an effective date of 6/22/15, indicated under responsibilities that the staff member: Assists with procedures and/or patient with tending to personal care, activities of daily living and/or transfers/transport.</p> <p>4. Review of personnel files for staff members N15 and N17 indicated they were both hired 11/16/15 and lacked</p>		<p>care to our patient. Monitoring: To ensure compliance, beginning in July 2016, St. Vincent HR and Talent Acquisition Management will review 70 personnel files of new associates to ensure the nurses aide registry was checked in a timely manner and results of same were recorded in their file. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audits will be communicated through Operations and Accreditation Committee. Responsible Person: Director of Human Resources or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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S 0178 Bldg. 00	<p>documentation of IPLA (Indiana public licensing agency) check related to the nurse aide registry check required by State law.</p> <p>5. At 11:00 AM on 5/18/16, interview with staff members #71 and #72, human resources director and staff member, confirmed that the IPLA was not listed by the contracted company as one of the agencies that are checked for nurse aides without licensure as part of their background check as a patient care tech.</p> <p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and interview the facility failed to ensure the posting of the hospital license at one off site toured.</p> <p>Findings Include: 1. At 9:10 AM on 5/17/16 while touring the off site cath lab (within the Heart Hospital) at 10590 N. Meridian St., in the company of the director of accreditation</p>	S 0178	<p>410 IAC 15-1.3-2 (a) S178 Posting of license in conspicuous location On or before May 20, 2016, a copy of the hospital's current license was conspicuously posted in an area open to patients and thepublic. 1) Outpatient Cath Lab in Heart Center reception area. Responsible Person: Safety Officer ensured the current ISDH</p>	05/20/2016

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S 0308 Bldg. 00	<p>and patient safety, staff member #52, it was observed that there was no copy of the facility license posted at the off site.</p> <p>2. Staff member #52 confirmed at 9:15 AM on 5/17/16 that there was no hospital license posted at this off site.</p> <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 governing board failed to ensure the completion of orientation for 1 of 3 contracted EVS (environmental services)/housekeeping staff members, staff member N9.</p> <p>Findings Include: 1. Review of the employee file for N9 indicated they were hired on 6/30/14 and had an "Individual Training Record" by the contracted company in which the</p>	S 0308	<p>license was posted.</p> <p>410 IAC 15-1.4-2 (c) (6) (B) S308 GoverningBoard- Documentation of orientation Failed to ensure the completion of orientation for one EVShousekeeping staff member Corrective Action(s): Monitoring: On or before July 8, 2016, EVS Director or his designee will audit EVS personnel training records to ensure their orientation and training records are consistently completed in their entirety including but not limited to the following documents- document entitled</p>	07/08/2016

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S 0312 Bldg. 00	<p>middle portion of page one under "General Cleaning" with >13 steps to be signed off for training and competencies was left blank. The back side of the form was not signed by the new employee in the area: "I have been trained in all of the above topics. Trainee Signature: _____".</p> <p>2. At 3:55 PM on 5/17/16, interview with staff member #64, the human resources generalist for the contracted EVS company confirmed that the training form for staff member N9 was not completed, as listed in 1. above.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</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>(D) Annual performance evaluations,</p>		<p>"General Cleaning" as well as ensuring the attestation on the back of the document that confirms the staff member has been trained in all of the aforementioned topics has been signed. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audits will be communicated through Operations and Accreditation Committee. Responsible Person(s): Director of Environmental Services or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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	<p>based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview the governing board failed to provide a job description for the current ICP (infection control preventionist), staff member N18; failed to ensure annual performance evaluations per policy for 2 of 2 contracted dialysis nurses, N1 and N2.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of the personnel file for the ICP, staff member N18, indicated there was no job description for this position in the employee's file. At 10:55 AM on 5/19/16, interview with staff members #53, the Director of Clinical Excellence, and N18, the ICP, confirmed that the current job description for the Quality position (Job Title: PL-Quality) does not include any information, such as duties, performance and ongoing infection prevention education and training expectations, regarding the ICP position N18 which was added to their responsibilities in October 2015. Review of the policy Performance 	S 0312	<p>410 IAC 15-1.4-1 (c) (6) (d) S312 Governing Board- job description for one infection control preventionist and failed to perform to annual performance evaluations for 2 dialysis contracted nurses Corrective Action(s): 1) Job Description for Infection Preventionist- On May 22, 2016, the Infection Control Preventionist was changed from a PL (Process Leader)-Quality into the role of Director of Infection Prevention. As of June 1, 2016 the Director of Infection Prevention has completed job specific training, including Infection Control Risk Assessment Construction Trades and Best Practices, Indiana Patient Safety Summit, and attended the APIC Conference with a focus on hand hygiene, ambulatory care infection prevention, disinfection and sterilization, waterborne pathogen, endoscope reprocessing, and infection prevention and surveillance in primary care. The Director of Infection Prevention job description requires the individual to hold a valid Registered Nurse license in the State of Indiana, have a Master's degree, and five years of experience. The</p>	06/17/2016

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	<p>Management, policy number 1430876, last revised 04/2015, indicated under "Procedure":</p> <p>A. I. Implementation and Administration...Documentation of the annual performance plan, feedback/progress notes will be documented in the standard templates as development by Human Resources annually.</p> <p>B. III. Common Review: C. managers have the accountability for ensuring that all documentation is completed and signed by both the associate and appraiser before submission to Human Resources.</p> <p>4. Review of employee files indicated:</p> <p>A. Contracted Dialysis nurse N1 was hired 9/5/84 and had a performance evaluation dated 4/1/16 that was not signed at the time of employee file review on 5/17/16.</p> <p>B. Contracted Dialysis nurse N2 was hired 10/5/09 and had a performance evaluation dated 4/5/16 that was not signed at the time of employee file review on 5/17/16.</p> <p>5. At 11:00 AM on 5/17/16 and 1:35 PM on 5/18/16, interview with staff member #73, the contracted dialysis manager, confirmed that:</p> <p>A. The contracted dialysis company</p>		<p>ICP meets all requirements of this role. 2) Performance Evaluation meeting and signature for two contracted Dialysis Nurses- While the surveyor was still onsite the two dialysis nurses received their performance evaluation and signed the same. Further, on June 17, 2016, the Dialysis manager met with each dialysis nurse to share their performance evaluation and authenticated by the appraiser and staff member. Monitoring: Beginning in July 2016, the Director of Inpatient Dialysis or his designee will audit all dialysis nurse personnel files to ensure they contain performance evaluations on an annual basis, that the manager met with the nurse to discuss, and that the evaluation was signed. Responsible Person(s): The Director of Inpatient Dialysis or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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S 0330 Bldg. 00	<p>policy requires authentication by a staff member after receiving their annual performance evaluation.</p> <p>B. N1 and N2 received notification in April 2016 of their "scores" and pay increases, but were not presented with the formal evaluations.</p> <p>C. The performance evaluations reviewed on 5/17/16 were not signed by N1 and N2 at that time.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on record review, and staff interview, the facility failed to maintain complete records of employees post offer physicals, immunizations, and tuberculin</p>	S 0330	410 IAC 15-1.4-1 (c) (6) (K) S330 Governing Board-Failed to maintain completed records of employees post offer	07/08/2016			

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S 0596 Bldg. 00	<p>tests or x-rays for 4 of 12 food service employees reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of Touch Point contracted personnel files for the 12 selected food service employees from both hospital's began on 5/18/16. <ol style="list-style-type: none"> Staff members CP9, CP17, and CP23 were missing post offer physicals, Staff members CP17, CP21, and CP23 were missing documentation for Rubella, Rubeola, and Varicella. In interview on 5/19/16 at 2:00 p.m. SP#1 confirms all available health information was provided and documentation of above listed employees is not in employee files. <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p>		<p>physicals, immunizations, tb tests or x-rays for 4 food service employees. Corrective Action(s): While surveyors were onsite the 4 food service employees with missing employee records were immediately released from work and sent to get the treatment they needed, i.e., post offer physical or immunization. Monitoring: Beginning in July 2016, an audit of the food service employee personnel files will be completed to ensure post offer physicals and required immunizations have been completed and are documented. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audits will be communicated through Operations and Accreditation Committee. Responsible Person(s): The Food Service manager or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>		

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	<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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and interview, the infection control committee failed to approve the cleaning products and processes of the contracted cleaning company at the off site cath lab.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of the policy Cleaning, Disinfection, Sterilization, and Single Use Care Items, policy number 2184337, last revised 3/2016, indicated on page 2 under Policy: B. All cleaning and disinfectant products must be submitted for approval by the respective hospitals Executive Infection Control and IP (infection prevention) Pathology Committees. Review of the list of cleaning products used by the contracted housekeeping company on the form "Orientation Check 	S 0596	<p>410 IAC 15-1.2(f) (3) (D)(iii) S596-Infection Control- Infection control committee failed to approve the cleaning products and processes of the contracted cleaning company at the off-site Cath lab. Corrective Action(s): On July 5, 2016, the ambulatory site Infection Preventionist received an updated list of the cleaning products and processes used at the off-site Cath lab. After review and research of the cleaning products the Infection Preventionist advised that the contracted cleaning company use the hospital approved cleaning products and processes. On or before July 8, 2016, the Executive Infection Prevention Committee reviewed and approved the cleaning products via electronic vote. Monitoring: To ensure compliance, beginning July 2016, the Environment of Care Rounding Tool was reviewed and</p>	07/08/2016

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	<p>List" B&J Janitorial Services", indicated Husky #7007, 702, 305 and 814 were used along with a stainless steel cleaner, a floor stripper and wax, and vinegar and water.</p> <p>3. Review of the B&J/Duke/JLL cleaning specifications documents indicated office areas, lobby, corridors and elevators, restrooms, break rooms/cafeteria/kitchens, and stairways all had a daily/weekly/monthly and annual cleaning expectation and checklists for these areas.</p> <p>4. At 3:15 PM on 5/17/16, interview with the infection preventionist, #63, confirmed that:</p> <p>A. B & J and JLL are the same company and Duke was the previous company responsible for off site cleaning at the cath lab off site areas.</p> <p>B. The company was instructed that vinegar and water were not approved as cleaning products.</p> <p>C. The list of Husky and other products was from a 7/29/15 fax and no current listing of products used was available.</p> <p>D. The cleaning products and processes performed at the off site cath lab were presented at an infection control committee meeting in the past, but never given committee approval.</p>		<p>revised to ensure that cleaners used at the ambulatory sites by contracted workers have been approved by the Executive Infection Control Committee.</p> <p>Responsible Person(s): Director of Infection Prevention and Control or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>		

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S 0606 Bldg. 00	<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. Based on document review and interview the infection control committee failed to ensure the communicable disease history for 2 of 3 contracted EVS (environmental services) staff in regard to Hepatitis B, staff members N8 and N10 and for 1 of 1 agency CST (certified surgical tech), staff member N5.</p> <p>Findings Include: 1. Review of the policy Pre-Placement Physical Examination, policy number 1072251, last revised 12/2014, indicated on page two under Procedure, II. Pre-Placement Medical Screening: 15. Assessment of Immunity status for:...e.</p>	S 0606	<p>410 IAC 15-1.5-2 (f) (3) (D) (viii) S606-Infection Control Infection control committee failed to ensure the communicable disease history for 2 contracted EVS workers and one contracted CST in regards to Hepatitis B. Corrective Action(s): 2 EVS workers- Corrective Action(s): While surveyors were onsite the 2 EVS workers with missing acceptance of Hepatitis B series or declination form were released from work and sent to get the treatment they needed. Monitoring: Beginning in July 2016, an audit of the environmental service personnel files will be completed to ensure there is documentation in their</p>	07/08/2016			

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	<p>Hepatitis B...16. Providing Immunization for:...c. Hepatitis B or obtaining signed Declination if offer declined.</p> <p>2. Review of personnel files indicated: A. Agency CST N5 was hired 1/11/16 and had documentation of a Negative titer for Hepatitis B surface AG (antigen) with a reported date of 1/7/16 and notation on 1/8/15 of a Hepatitis B "Accept/Decl Form" (acceptance or declination form) having been "Completed", with no form present in the personnel file. B. Contracted EVS staff member N8 was hired 11/30/15 and had no acceptance/declination form for Hepatitis B in their file. C. Contracted EVS staff member N10 was hired 4/21/14, had a "non reactive" Hepatitis B titer in the file, and had no acceptance/declination form for Hepatitis B in their file.</p> <p>3. At 12:55 PM on 5/17/16, interview with the COO (chief operating officer) for the contracted nursing agency, confirmed that CST N5 had no signed Hepatitis B declination form even though a document in the file indicated one had been signed 1/8/15.</p> <p>4. At 3:55 PM on 5/17/16, interview</p>		<p>files to reflect either acceptance of the hepatitis B series or declination. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audits will be communicated through Operations and Accreditation Committee. Responsible Person(s): Director of Environmental Services or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Certified Scrub Technician- Corrective Action(s): While surveyors were still onsite the CST without documentation of either acceptance or declination of Hepatitis B series was contacted and his declination form was signed, scanned and placed into his personnel file. Monitoring: Beginning in July 2016, an audit of the Certified Scrub Technician personnel files will be completed to ensure there is documentation in their files to reflect either acceptance of the hepatitis B series or declination. This audit will be completed for a 3 month period with expectations for</p>	

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S 0608 Bldg. 00	<p>with staff member #64, the human resources generalist for the contracted EVS company, confirmed that N8 and N10 should have had confirmation of having had the Hepatitis B series, a positive titer for Hepatitis B, or a signed declination form in their files, and none of those could be found to have been done at the time of hire for those two staff members.</p> <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. Based on observation and interview the infection preventionist failed to ensure</p>			S 0608	<p>achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audits will be communicated through Operations and Accreditation Committee. Responsible Person(s): Director of Patient Care Services or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p> <p>410 IAC 15-1.5-2 (f) (3) (D)(ix) S608 -Infection Control - Failure</p>		07/08/2016

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	<p>proper attire was adhered to in the surgical area of the facility in relation to one EVS (environmental services) employee observed, staff member #74.</p> <p>Findings Include:</p> <p>1. At 9:42 AM on 5/18/16 while on tour of the surgical suites area, specifically near suite #1 in the pediatric surgical area, in the company of surgery manager #75 and surgery director #76, it was observed that EVS manager #74 was entering and exiting surgical suites with a white "bunny suit" on, but with black dress shoes which were not covered.</p> <p>2. At 9:45 AM on 5/18/16, staff member #76 confirmed that the EVS staff member did not have on dedicated surgery shoes in the restricted surgery area, but instead had "street" shoes on that were not covered, as required by the facility and is a standard of practice.</p>		<p>to ensure proper attire was adhered to in the surgical area of the facility in relation to EVS employee wearing black dress shoes. Corrective Action(s): On or before July 8, 2016, the Contracted EVS leaders and staff who provide services to the operating room suite were reeducated that if shoes are not dedicated to use in the surgical suites then street shoes must be covered with shoe protectors before entering into the operating room area. Additionally, a memorandum of understanding was disseminated through vendor credentialing system to remind vendors coming into the operating room area that shoe covers are necessary when street shoes are worn. Monitoring: Beginning in July 2016, the operating room rounding audit tool will be revised to include checking vendors for shoe covers while in the Operating room setting. Any identified gaps will immediately be discussed with the vendor or associate on an individual basis for performance improvement. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period</p>		

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S 0912 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE</p> <p>410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and</p>		reflects the achievement of the threshold. Results of the audits will be communicated through Operations and Accreditation Committee. Responsible Person(s): Director of Perioperative Services or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.	

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	<p>procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review, observation and interview, the nursing executive failed to ensure that blanket warmers in two areas were cleaned by staff as required per expectations and checklist; failed to ensure the cleaning of nursing (computer) equipment in one area; and failed to implement the assessment policy in relation to the lack of a head circumference measurement on admission for 1 of 1 pediatric chart for a child less than one year of age, Pt. # 47.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of the Steris/Amsco maintenance manual for blanket warmers indicated on page 4-1 that a stainless steel cleaner and polish is to be used on the stainless steel portions of the blanket warmers and to "use a mild detergent solution...to wash non-stainless steel surfaces...". Review of the "St. Vincent Indianapolis Hospital - Blanket Warmer Temperature Log" indicated an area for staff to check if: "Warmer is Clean" and to "(check if yes, note cleaning in action column)". 	S 0912	<p>410 IAC 15-15-6 (a) (2) (B) (i) (iii) (iv) (v) S912 -Nursing Service- Failed to ensure the blanket warmers in two areas were cleaned by staff according to expectations and checklist; cleaning of nursing computer equipment in one area, to implement the assessment policy in relation to lack of head circumference measurement on admission for 1 pediatric chart. Blanket warmers- Corrective Action(s): On July 8, 2016, the nurses in the Labor and Delivery Unit and Pre-Op areas were reeducated regarding the importance of viewing and cleaning the blanket warmers at least once per day to ensure they are free of dust and debris. If the blanket warmer has dust and debris then it is removed and cleaned. Monitoring: Beginning in July 2016, the nurse managers on Labor and Delivery and Pre-Op will begin a monthly audit to ensure that blanket warmers are checked daily for cleanliness and are free of dust and debris (specifically staff will check for accumulation of dust in the air circulating area under the perforated bottom shelf of the warmers and clean when warranted). This audit will be</p>	07/08/2016

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	<p>3. At 1:15 PM on 5/17/16, while on tour of the Women's Hospital L & D (labor and delivery) unit in the company of the nursing director, staff member A23, and the L & D manager, A28, it was observed in operating room #3 that there was an accumulation of dust in the air circulating area under the perforated bottom shelf of a single compartment Amsco blanket warmer.</p> <p>4. At 1:20 PM on 5/17/16, staff A23 and A28 confirmed the presence of dust in the blanket warmer and confirmed the equipment had not been maintained as expected.</p> <p>5. At 9:20 AM on 5/18/16, while on tour of the adult pre op area of the facility in the company of staff member #69, the pre op manager, and #52, the director of accreditation and patient safety, it was observed that there was a large accumulation of dust under the bottom shelf of the top cabinet of the Amsco/Steris blanket warmer.</p> <p>6. At 9:25 AM on 5/18/16, staff members #69 and #52 confirmed that the blanket warmer had an accumulation of dust and that this was not acceptable in relation to cleanliness related to possible infection issues, and a possible fire</p>		<p>completed for a 3 month period with expectations for achievement of 90%or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audits will be communicated through Operations and Accreditation Committee. Responsible Person(s): The Chief Nursing Officer or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Nursing computer equipment-Corrective Action(s): July 8, 2016, EVS staff was educated to clean the base of computer rovers in the Pediatric Intensive Care Unit at a minimum of once weekly to ensure prevention of possible infection issues when rovers are taken in and out of patient rooms. Beginning July 2016, EVS (Environmental Services) staff member will clean the bases of nursing rover computers on a weekly basis to ensure they are free from dust and debris. Monitoring: To ensure compliance beginning in July 2016, the EVS manager or designee will initiate a monthly audit to ensure that computer rover base sare clean and free from dust and debris. Any</p>				

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	<p>hazard.</p> <p>7. Review of the policy Cleaning, Disinfection, Sterilization, and Single Use Care Items, policy number 2184337, last revised 3/2016, indicated on page 2 under "C. Noncritical items: 1. Noncritical items require low level disinfection after each patient/guest use...".</p> <p>8. At 10:50 AM on 5/18/16 while on tour of the PICU (pediatric intensive care unit) in the company of staff members #68, the unit manager, and #52, the director of accreditation and patient safety, it was observed that the "Rover" (computer on wheels) had an accumulation of dust/debris on the base of the equipment.</p> <p>9. At 10:50 AM on 5/18/16, staff members #68 and #52 confirmed that: A. The Rovers can be taken into patient rooms for electronic medical record documentation. B. Nursing staff are responsible for cleaning the Rovers routinely.</p> <p>10. Review of the policy Patient Assessment/Reassessment, policy number 2235874, last revised 3/2016, indicated on page 4 under "Additional Elements of Assessment", in A. 8. "Head</p>		<p>identified gaps will be immediately discussed with EVS staff on an individual basis for performance improvement. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audits will be communicated through the Operations Accreditation Committee. Responsible Person(s): The Director of Environmental Services or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Documentation of head circumference in infant under 1 years of age- Corrective Action(s): Peyton Manning Children's Hospital Nursing Director reviewed assessment policy and procedure to ensure they appropriately identified the required standards of practice and no revisions were warranted. On or before July 8, 2016, the Peyton Manning Children's Hospital nurses were reeducated regarding the importance of measuring and documenting head circumference of our pediatric patients up to one year of age. Monitoring: To</p>	

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S 1118 Bldg. 00	<p>circumference (up to one year of age)".</p> <p>11. Review of one medical record for a patient less than one year of age, Pt. #47, indicated the 6 month old child was admitted on 2/1/16, discharged on 2/2/16, and had no documentation in the record that would indicate a head circumference measurement had been done.</p> <p>12. At 1:40 PM on 5/18/16, interview with quality consultants #78 and #79, confirmed that there was no head circumference measurement documented in the medical record for Pt. #47.</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</p>		<p>ensure compliance beginning in July 2016, Peyton Manning Children's Hospital Nursing Director or her designee conducts monthly audits of patient medical records to ensure that head circumference, for patients less than one year of age, is measured and documented in the record per assessment policy and procedure. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Responsible Person(s): The Director of Peyton Manning Children's Hospital or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>		

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	<p>maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 2 instances.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of PolicyStat ID : 1130179, entitled Compressed Gas Cylinder Safety, Last Revised: 10/24, indicated all gas cylinders shall be held securely in approved carriers, holding racks or chained to walls. On 05-16-2016 at 2:30 pm in the presence of employees #A5 (Executive Director Quality), #A6 (Facilities Services), and #A7 (Facilities Manager), it was observed in the chiller room of the physical plant area there was 1 acetylene compressed gas cylinder standing upright on the floor unsecured by chain or holder. Review of a document entitled BOEKEL Contrast Incubator, Warmer Location Rm 5, Month May Year 2016, indicated on Date 10 and 11, Temperature (Celsius) was 37.3 and 27.9, respectively. The document states "should be close to normal body temperature (37 degrees) 	S 1118	<p>410 IAC 15-1.5-8 (b) (2) S1118-Physical Plant The hospital created conditions which resulted in a hazard to patients, public, or employees. Acetylene compressed gas cylinder- While the surveyor was still onsite the unsecured gas cylinder in the chiller room of the physical plant area was secured to protect potential insult to person or property. Responsible Person(s): The Director of Facilities or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p> <p>Contrast Warmer- Corrective Action(s): On or before May 20, 2016 the contrast warmer temperature log was reviewed and revised to include a column titled "second temperature" and another column entitled "corrective action" to remind staff that when the warmer temperature is over 37 degrees Celsius that another temperature should be taken and recorded and if still too high then the unit taken out of service and engineering contacted. Staff that check record contrast warmer temperatures were reeducated regarding the importance of rechecking contrast temperature and taking corrective action if warranted so the contrast will not injure the patient. Monitoring:</p>	07/08/2016

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	<p>but range not to exceed 37 degrees celsius."</p> <p>4. Further review of the document entitled BOEKEL Contrast Incubator, indicated: if warmer is out of range:</p> <ol style="list-style-type: none"> Record corrective action plan to recheck temperature in 1 hour. Recheck temperature in one hour. If within standard, No further action is needed. If the temperature is outside of standard, take warmer out of service and report to Engineering. <p>5. Further review of the document entitled BOEKEL Contrast Incubator, indicated there were no entries to recheck the temperature in one hour, no recheck of the temperature an hour later, and no taking of the warmer out of service and report to Engineering.</p> <p>6. In interview on 05-16-2016 at 2:30 pm, employee #A13, Radiology Tech Supervisor, confirmed all the above incubator documentation and indicated there was no documentation to recheck the temperatures above 37 degrees Celsius.</p>		<p>To ensure compliance, beginning July 2016, the contrast warmer temp logs will be reviewed to ensure if the temperature is higher than 37 degrees Celsius that a temperature is checked again and then taken out of service if needed. Any identified gaps will immediately be discussed with the associate on an individual basis for performance improvement. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audits will be communicated through the Accreditation and Operations Committee. Responsible Person(s): The Director of Medical Imaging Services or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>		

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S 1125 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(B)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(B) Operational and maintenance control records shall be established and analyzed periodically. These records shall be readily available on the premises.</p> <p>Based on interview, the facility failed to document detail of the annual preventive maintenance (PM) for 1 of 7 systems of equipment, and failed to document operational and maintenance control records having been analyzed at least triennially for 4 of 7 systems of equipment.</p> <p>Findings include:</p> <p>1. On 05-16-2016 at 10:30 am, employee #A6, Facilities Services, was requested to</p>	S 1125	<p>410 IAC 15-1.5-8 (b) (5) (B) S1125-Physical Plant- Facility failed to document detail of annual preventative maintenance for one system of equipment. Facility failed to document operational and maintenance control records having been analyzed at least triennially for 4 systems of equipment. Elevator annual PM inaccessible at time of survey- At the time of the survey the annual elevator PM records were not accessible but are currently readily available on the premises for review.</p>	07/08/2016

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S 1160 Bldg. 00	<p>provide documentation of the detail of annual PM for the elevators.</p> <p>2. Interview of employee #A11, Safety/Emergency Management Officer, on 05-18-2016 at 12:15 pm, confirmed there was no documentation for the detail of the annual PM of the elevators and no other documentation was provided prior to exit.</p> <p>3. On 05-16-2016 at 10:30 am, employee #A6 was requested to provide documentation of the operational and maintenance control records for the air (vacuum) pump, boiler, elevator, and emergency generator, having been analyzed at least triennially.</p> <p>4. Interview of employee #A11 on 05-18-2016 at 12:15 pm, confirmed there was no documentation for the air (vacuum) pump, boiler, elevator, and emergency generator having been analyzed at least triennially, and no other documentation was provided prior to exit.</p>		<p>Evidence Operational and Maintenance Control Records for air (vacuum) pump, boiler, elevator, and emergency generator have been analyzed at least triennially- During June 2016, our Preventive Maintenance Management computer system was changed to another database- FSI/CMS so during the process all preventative maintenance records were reviewed and analyzed bringing them into compliance with ISDH requirements including but not limited to those records for the air (vacuum) pump, boiler, elevator, and emergency generator. Responsible Person(s): The Director of Facilities or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>		
	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)				

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	<p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on document review, interview and observation, the facility failed to have a policy to regularly maintain 1 piece of patient care equipment in accordance with the manufacturer ' s recommendations, failed to ensure two (2) off site eye wash stations were checked monthly per expectations, and failed to ensure equipment was maintained in good workign order for one blanket warmer and one ice machine.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 05-16-2016 at 10:30 am, employee #A6, Facilities Services, was requested to provide documentation of a policy to conduct preventive maintenance for a renal dialysis machine used by a contractor at the facility. 2. Interview of employee #A12, Trimedx staff, indicated there was no policy available and no other documentation was provided prior to exit. 3. At 9:45 AM on 5/17/16, while on tour of the off site cath lab at the North Meridian Heart Hospital in the company of staff member #52, the director of 	S 1160	<p>410 IAC 15-1.5-8 (d) (1)</p> <p>S1160-Physical Plant- Failed to have a policy to regularly maintain 1 piece of patient care equipment in accordance with the manufacturer's recommendations (dialysis machine), failed to ensure two eye wash stations were checked monthly per expectations, and failed to ensure equipment was in good working order for one blanket warmer and one ice machine. Dialysis Machine- Corrective Action(s): At the time of the survey, we were not able to corroborate the PM schedule to the manufacturer's recommendations for the particular dialysis unit. Since this time, we have obtained the manufacturer's manual for the unit and validated that the PM schedule we use is in sync with the manufacturer's recommendations, which are at six months and again at four thousand hours. Also, have added the Fresenius team to the EOC Medical Equipment Sub-Committee which meets monthly to ensure their reports are captured. Conducted training with the Fresenius Inpatient Services Program Manager on the importance of keeping all PM records and manufacturer's</p>	07/08/2016

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	<p>accreditation and patient safety, it was observed in the sheath pull room and the prep room that weekly "visual inspections" were conducted (by nursing staff) of the eye wash stations in these areas, per the checklist titled "St. Vincent...Cleaning Month/Year".</p> <p>4. At 11:55 AM on 5/18/16, interview with staff member #52 confirmed that:</p> <p>A. Per conversation with facilities staff, the off site eye wash locations are to be checked by facilities staff on a monthly basis, but "fell through the cracks" and have not been done.</p> <p>B. Upon checking 3 stations at the North Meridian cath lab on 5/17/16 (after surveyor touring) it was noted that only one of three stations had a water flow that could be used.</p> <p>5. During a tour of the Women's Hospital labor and delivery (L&D) unit on 5-17-16 at 1235 hours, in the company of the nursing director, staff A23, the L&D manager, staff A28, and the quality consultant, staff A22, the following condition was observed in the nourishment area: a Scotsman tabletop ice machine (asset ID FM20594567) with a 40mm x 40mm area of dark brown-colored surface residue (suspected mold) on the underside of the horizontal splash panel to the left of the ice dispensing outlet, a 5mm x 50mm area of brown-colored surface residue on the</p>		<p>manuals and PM recommendations readily available to produce for surveys. Training was completed July 8th.</p> <p>Monitoring: Beginning in July 2016, the Senior Safety Officer will review the EOC Medical Equipment Sub-Committee reports to ensure findings are being reported and that any discrepancies are being addressed and corrected. Eye wash stations at outpatient Cath lab- Corrective Action(s): While the surveyors were still onsite a facilities staff member went to the site to confirm and ensure that water flow to the eye wash stations was working appropriately and would be ready to flush an associate's eye in the case of an exposure.</p> <p>Monitoring: Beginning July 2016, facilities rounds monthly on the outpatient Cath lab eye wash stations to ensure they are working appropriately. Additionally, the Nursing manager or her designee has incorporated the 86th street eye wash check form which covers all required elements and she will check the eye wash stations during her rounds to ensure it has appropriate water flow etc.</p> <p>Responsible Person(s): The Director of Facilities or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Labor and Delivery Nourishment Center table-top</p>	

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	<p>underside of the cabinet in front of the ice dispensing outlet, and a 2mm x 30mm crescent-shaped area of brown-colored residue on the lower end of the white plastic ice dispensing outlet of the ice machine.</p> <p>6. On 5-17-16 at 1227 hours, the nursing director, staff A23, and the L&D manager, staff A28, confirmed the presence of the brown-colored residues on the ice machine surfaces and confirmed that the equipment had not been maintained.</p> <p>7. During a tour of the Women's Hospital L&D surgical suites on 5-17-16 at 1315 hours, in the company of the nursing director, staff A23, the L&D manager, staff A28, and the quality consultant, staff A22, the following condition was observed in the operating room #3: the presence of accumulated dust in the air circulating area under the perforated bottom shelf of a single-compartment Amsco blanket warmer.</p> <p>8. On 5-17-16 at 1320 hours, the nursing director, staff A23, and the L&D manager, staff A28, confirmed the presence of dust in the blanket warmer and confirmed the equipment had not been maintained.</p>		<p>ice machine- Corrective Action(s): Prior to surveyors' arrival for survey a work order had been placed to repair and clean this table top ice machine. While surveyors were onsite, ice for patients and staff on this unit, for human consumption, was brought in from another area of the hospital so they would not be affected by this machine.</p> <p>Responsible Person(s): The Director of Facilities or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Labor and Delivery Blanket Warmer lower shelf dusty- Corrective Action(s): On July 6, 2016, the Blanket Warmer Temperature Log policy and procedure and form was reviewed by Facilities and Nursing and determined they appropriately identified the standards of practice and no revision was warranted at this time. On or before July 8, 2016, nurses in Labor and Delivery, Pre-Operative Areas, were reeducated regarding the importance of checking the blanket warmer for cleanliness, especially on the bottom perforated shelf to ensure dust has not accumulated, as well as assessing for appropriate temperature range. Monitoring: To ensure compliance, beginning in July 2016, the nursing managers for L&D, Pre-Operative or her designee will perform a</p>				

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S 1164 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (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,		monthly audit of blanket warmers to ensure that the bottom perforated shelf is free from the accumulation of dust and debris. Any identified gaps will be immediately be discussed with respective nursing staff member on an individual basis for performance improvement. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audit will be communicated through the Operations and Accreditation Committee. Responsible Person(s): The Director of Nursing for these units or her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.	

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S 1166 Bldg. 00	<p>as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on interview, the hospital failed to provide documentation of preventive maintenance (PM) for 2 of 24 pieces of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 05-16-2016 at 10:30 am, employee #A6, Facility Services, was requested to provide documentation of PM on an audiometer and floor scrubber. In interview on 05-18-2016 at 3:15 pm, employee #A12, Trimedx staff, indicated there was no documentation and none was provided prior to exit. <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>(C) Appropriate records shall be kept pertaining to equipment</p>	S 1164	<p>410 IAC 15-1.5-8 (d) (2) (b) S1164-Physical Plant- Hospital failed to provide documentation of PM for 2 pieces of equipment. (Audiometer, floor scrubber) Corrective Action(s): On or before July 8, 2016, Director of Environmental Services and Facilities met to ensure that they could immediately access Preventative Maintenance records for these devices. Responsible Person(s): Director of Facilities or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>	07/08/2016

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S 1166	<p>maintenance, repairs, and current leakage checks.</p> <p>Based on document review and interview, the hospital failed to document a current leakage check on 3 of 24 pieces of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 05-16-2016 at 10:30 am, employee #A6, Facilities Service, was requested to provide documentation of current electrical leakage checks for 24 pieces of equipment. Review of documents indicated there was no documentation of current electrical leakage check for a an audiometer, C-arm/portable x-ray, and a floor scrubber. In interview on 05-18-2016 at 3:30 pm, employee #A12, Trimedx staff, confirmed there was no above-requested documentation. No other documentation was provided prior to exit. 	S 1166	<p>410 IAC 15-1.5-8 (d) (2) (c)</p> <p>S1166-Physical Plant- Hospital failed to document a current leakage check on 3 pieces of equipment. (Audiometer, C-arm portable x-ray, floor scrubber)</p> <p>Corrective Action(s): On or before July 8, 2016, Facilities and EVS reached out to vendors who PM the following pieces of equipment- (audiometer, C-arm portable x-ray, and floor scrubber) and sent them a revised PM form to use going forward that more clearly delineates that current leakage checks were performed on the equipment during the PM.</p> <p>Responsible Person(s): Director of Facilities or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>	07/08/2016
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</p>			

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	<p>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 contracted environmental services company and contracted dietary/food company failed to ensure the hospital surgical environment was maintained in a sanitary manner, that the patient care areas were effectively cleaned and disinfected, and that patient and pantry refrigerators and microwaves were clean and sanitary.</p> <p>Findings include:</p> <p>1. During a tour of the Women's Hospital L&D (labor and delivery) surgical suites on 5-17-16 at 1315 hours, in the company of the nursing director, staff A23, the L&D manager, staff A28, and the quality consultant, staff A22, the following condition was observed in the operating room #3: the presence of accumulated dust on one of two 18 " x 24 " wall ventilation grilles.</p>	S 1172	<p>410 IAC 15-1.5-8 (e)(1)(A) (B) (C) S 1172-Physical Plant- Contracted EVS and dietary/food company failed to ensure the hospital surgical environment was maintained in a sanitary manner, patient care areas were effectively cleaned and disinfected, and that patient and pantry refrigerators were clean and sanitary. Women's Hospital Labor and Delivery Surgical Suite #3, Central Sterile Decontamination Room- Corrective Action(s): By July 8, 2016, EVS workers were reeducated through morning huddles to emphasize the appropriate procedure and schedule for high dusting and what areas at a minimum are included-(specifically mentioned were tops of equipment and cabinets, ledges, sills, lights, ceiling vents. Monitoring: Beginning in July 2016, EVS managers or their designee will perform monthly audits on the following units: Labor and</p>	07/08/2016

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	<p>2. On 5-17-16 at 1320 hours, the nursing director, staff A23, and the L&D manager, staff A28, confirmed the presence of dust on the ventilation grille and confirmed the condition was unsanitary.</p> <p>3. During a tour of the Women's Hospital first floor surgical suites on 5-17-16 at 1430 hours, in the company of the nursing director, staff A23, the surgery manager, staff A29, and the quality consultant, staff A22, the following condition was observed in the central sterile decontamination room: the presence of accumulated dust on a 24 " x 24 " ceiling ventilation grille.</p> <p>4. On 5-17-16 at 1430 hours, the nursing director, staff A23, and the surgery manager, staff A29, confirmed the presence of dust on the ventilation grille and confirmed the condition was unsanitary.</p> <p>5. The product description and label for the hospital disinfectant Virex II 256 indicated the following: " For use as a One-Step Cleaner/Disinfectant - Apply use solution to hard, non-porous environmental surfaces. To disinfect, all surfaces must remain wet for 10 minutes. "</p>		<p>Delivery, Women's Central Sterile- Decontam room, to ensure that vents are clean and free of dust and debris. Any identified gaps will be immediately discussed with the EVS staff member on an individual basis for performance improvement. This audit will be completed for a 3 month period with expectations for achievement of the threshold. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3 month period reflects the achievement of the threshold. Results of the audit will be communicated through the Operations and Accreditation Committee. Responsible Person(s): The Director of EVS or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Virex dry time- Corrective Action(s): By July 8, 2016, EVS staff members were reeducated during morning huddles regarding the use of Virex and specifically its dry time to ensure the product has appropriate contact time to disinfect the surface. Responsible Person(s): The Director of EVS or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Disinfection of Patient room</p>		

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	<p>6. On interview on 5-17-16 at 1145 hours, in the company of the nursing director, staff A23, and high-risk unit manager, staff A30, the environmental services (EVS) personnel, staff A31, indicated the wet contact time for the Virex II disinfectant was 5 minutes.</p> <p>7. On interview on 5-17-16 at 1145 hours, the nursing director, staff A23, confirmed the wet contact time for Virex II disinfectant was 10 minutes and the nursing director re-educated the EVS personnel on the proper use of the disinfectant at the facility.</p> <p>8. Review of the policy Bloodborne Pathogen Exposure Control Plan FY (fiscal year) 2016, policy number 1758249, last revised 9/2015, indicated on page 4 under section E. Housekeeping: 3. Equipment and working surfaces are cleaned and decontaminated after contact with blood or OPIM (other potentially infected material).</p> <p>9. Interview with the contracted housekeeper, N10 at 11:15 AM on 5/16/16, confirmed that patient room floors are not disinfected when terminal cleaning is done after the patient is discharged. Instead, a product called Stride, a general purpose cleaner, is used.</p>		<p>floors during terminal clean- Beginning in July 2016, EVS will use a disinfectant to clean patient room floors during terminal cleans. Responsible Person(s): The Director of EVS or his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. 6th floor medical oncology unit-ceiling vent dust and debris, personal room refrigerator had drinks and food after patient had discharged from the hospital, and temperature log had not been documented as being completed per hospital policy. Medical Behavior Unit-debris and spilled liquid in the refrigerator, crumbs in storage cabinets and pantry, splashed material on the top of the microwave, Medical Oncology Unit-patient food refrigerator had debris in the freezer and under the vegetable/crisper drawers. Surgical Oncology Unit pantry area-three ceiling light panels had dust and debris on the inside edges of the panels. Cath lab-wall cabinets had dust and debris on the lower shelves, refrigerator in the pantry area- debris in the freezer and under the crisper drawers, dirty shelves on the inside of the refrigerator doors. Pre-Op-refrigerator-kick plate was stained/dirty and there was debris under the crisper drawers and the under glass shelf that rests on top of the crisper</p>	

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	<p>10. At 1:25 PM on 5/16/16, interview with the EVS (environmental services) director, #61, confirmed that Stride neutral cleaner is used for daily patient room (non-isolation) floor cleaning and for terminal floor cleaning.</p> <p>11. At 12:00 PM on 5/17/16, interview with one of the hospital infection preventionists, staff member #63, confirmed that when EVS staff enter a discharged patient room to complete terminal cleaning, they would not be aware if blood or body fluids (OPIM) had been present on the floor during the patient's hospital stay, and if the clean up/decontamination had been per the bloodborne pathogens policy, so that a disinfectant should be used at least at the time of terminal cleaning, if not with daily floor cleaning.</p> <p>12. Review of the policy Daily Patient Room Cleaning, policy number 2417501, last revised "N/A", indicated under Policy in item 3.: Using microfiber cloth and Virex disinfectant, damp high dust, beginning at the entranceway and working around the room in a circle. Damp high dust horizontal surfaces above shoulder height.</p> <p>13. Review of the policy Patient Unit</p>		<p>drawers PICU-dust on the window ledges of the glass and metal door to room #3 Corrective Action(s): Beginning on July 7, 2016, EVS staff were reeducated during morning huddles regarding the processes of ceiling vent dusting, cleaning of patient refrigerators upon discharge, monitoring and logging of patient refrigerator temperatures on 6 Oncology daily and when the patient is not there both the temperature and not occupied should be recorded on the temperature log. This huddle also included information about cleaning of door and window ledges on glass and metal doors. Beginning in July 2016, the Facilities department manager is putting ceiling light covers on a PM schedule to ensure they are as free as possible of dust and debris on the inner edges. On or before July 8, 2016 Dietary staff were reeducated regarding the process of cleaning pantry refrigerators with emphasis on cleanliness of freezers, kick plates, and removal of debris under crisper drawer and the glass shelf that rests on top of the crisper drawers. Additionally, they were reminded regarding cleaning inside of the microwave ovens and removal of crumbs in the dry storage areas. Monitoring: Beginning in July 2016, EVS managers or their designee will perform a monthly audit to ensure the following</p>		

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	<p>Refrigeration Units, policy number 345248, last approved 11/2013, indicated under Procedure, in A.: Temperature monitoring: 1. At St. Vincent 86th street the unit refrigerators are checked daily and food service personnel record temperatures a minimum of once in a twenty four hour calendar day. And, in section C. Cleaning: 2...At St. Vincent 86th street the unit refrigerators are wiped inside and out by Food & Nutrition Services associates using an approved sanitizing agent.</p> <p>14. Review of the policy Use of Microwaves, policy number 345305, last approved 11/2013, indicated under Policy: "The Food and Nutrition Service Department will monitor the use of the department's microwave ovens...". And, under "Procedure", it reads; "...c. Microwaves are routinely cleaned and sanitized.</p> <p>15. At 11:15 AM on 5/16/16 while on tour of the 6th floor medical oncology unit in the company of the director of accreditation and patient safety, #52, and the unit director, #56, it was observed in open/empty patient room #6622: A. The ceiling vent (12 inches by 12 inches--louvered) above the small refrigerator had a large accumulation of dust present.</p>		<p>items are cleaned appropriately--outside of ceiling vents, personal refrigerators are cleaned after patient discharge and temperature is assessed and logged. They will also observe PICU metal and glass sliding doors to ensure window ledge is clean and free of dust and debris. Managers will also look to ensure that the outside of pantry refrigerators are clean and not stained. Beginning in July 2016, the Dietary manager or her designee will perform a monthly audit to ensure the following items are cleaned appropriately--inside of microwaves, inside of pantry refrigerators, and inside of dry storage drawers to ensure they are clean and free from debris. By July 8, 2016, the wall cabinets were added to the Cath lab nursing rounding list to ensure the cabinets are dust and debris free. Any identified gaps will immediately be discussed with the appropriate staff member on an individual basis for performance improvement. These audits will continue for a 3 month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a 3 consecutive month period reflects achievement of the</p>		

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	<p>B. The personal room refrigerator had food present: 1 bottle of Pepsi, 1 bottle of water, 2 boxes of milk, and a container of cantaloupe.</p> <p>C. The temperature log on the refrigerator indicated the temperature had not been checked since 5/3/16.</p> <p>16. Interview with staff members #52 and #56 at 11:20 AM on 5/16/16 confirmed that the last patient had been discharged two days prior, on 5/14/16, and the contracted food/dietary and EVS staff had:</p> <p>A. Not disposed of food and drinks that were still present, had not cleaned the refrigerator unit after the patient's discharge, and the temperature had not been checked for 13 days.</p> <p>B. Failed to appropriately perform high dusting processes in relation to the ceiling louvered air vent which had a large accumulation of dust present.</p> <p>17. At 11:17 AM on 5/16/16, while on tour of the adult medical behavioral unit in the company of staff member #70, the nurse manager of the unit, indicated there was:</p> <p>A. Debris and spilled liquids in the refrigerator, and crumbs in dry storage cabinets of the pantry area.</p> <p>B. A large amount of splashed material on the inside top of the microwave in the</p>		<p>threshold. Results of the audits will be communicated through the Operations and Accreditation Committee. Responsible Person(s): Director of EVS and his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Director of Food and Nutrition and her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur. Manager of the Outpatient Cath Lab and her designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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	<p>kitchen/pantry.</p> <p>18. At 11:17 AM on 5/16/16, staff member #70 confirmed the finding and stated that dietary was responsible of the cleaning of the pantry refrigerator, cabinets, and microwave.</p> <p>19. At 1:05 PM on 5/16/16, contracted food/nutrition director, #60, confirmed that the contracted agency was to clean refrigerators and microwaves on an "as needed" basis, but that a routine cleaning schedule might be more prudent.</p> <p>20. At 10:25 AM on 5/17/16, interview with quality staff members #52 and #67 confirmed that in room 6622 a patient was present from mid April to 5/10/16 and another admitted 5/11/16 to 5/14/16 so that the refrigerator temperatures had not been taken the days that a patient was present after the last documentation on 5/3/16.</p> <p>21. At 11:22 AM on 5/16/16, while on tour of the 6th floor medical oncology unit in the company of the director of accreditation and patient safety, #52, and the unit director, #56, it was observed in the unit pantry that the patient food refrigerator had debris present in the freezer and under the vegetable/crisper drawers of the refrigerator.</p>			

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	<p>22. Interview with staff member #52 at 11:25 AM on 5/16/16 confirmed that the refrigerator needed to be cleaned.</p> <p>23. At 1:05 PM on 5/16/16, interview with the system director for the contracted food/nutrition services provider, #60, confirmed that pantry refrigerators were expected to be cleaned weekly but that there was no documentation for this process, and the company policy is not clear that routine versus "as needed" cleaning is to be done.</p> <p>24. At 2:35 PM on 5/16/16, while on tour of the 6 east Surgical oncology unit pantry area, it was observed that the three ceiling light panels had dust/debris on the inside edges of the panels.</p> <p>25. At 10:50 AM on 5/18/16, staff member #52 confirmed that facility maintenance staff reported they only clean the inside of the drop down ceiling panels "as needed", and that during EOC (environment of care) rounds the ceiling tiles need to be better observed for the presence of dust/debris to request their cleaning.</p> <p>26. At 9:18 AM on 5/17/16 while on tour of the off site cath lab in the company of staff member #52 and the off</p>			

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	<p>site director #62 it was observed that the wall cabinets in rooms #2 and #3 had dust and debris present on the lower shelves of the cabinets. Staff members #52 and #62 confirmed the cabinets had not been cleaned for some time.</p> <p>27. At 11:55 AM on 5/18/16, interview with staff member #52 confirmed that the cabinets at the off site cath lab were not on the cleaning checklists of either the contracted EVS company or the staff cleaning checklists so that it appears no one had been cleaning the cabinets in the patient rooms.</p> <p>28. At 9:35 AM on 5/17/16, while on tour of the off site cath lab in the company of staff members #52 and #62 it was observed that the refrigerator in the pantry area had debris present in the freezer and under the crisper drawers of the refrigerator, plus dirty shelves on the inside of the refrigerator door. Staff members #52 and #62 confirmed the refrigerator was dirty and needed cleaning.</p> <p>29. At 9:30 AM on 5/18/16 while on tour of the adult pre op area pantry in the company of staff member #52 and the pre op manager #69, it was observed that the kick plate of the refrigerator was stained/dirty and that there was debris</p>			

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S 1180 Bldg. 00	<p>under the crisper drawers and under the glass shelf edges that rest on top of the crisper drawers. Staff members #52 and #69 confirmed the refrigerator was not clean and sanitary.</p> <p>30. At 10:30 AM on 5/18/16 while on tour of the PICU (pediatric intensive care unit) in the company of staff member #52, and the unit manager, staff member #68, it was observed on the window ledge of the glass and metal door to room #3 that there were dusty ledges that EVS staff had failed to clean/disinfect. Staff member #52 and #68 confirmed the dusty presence.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(f)(1)</p> <p>(f) The safety management program shall include, but not be limited to, the following:</p> <p>(1) An ongoing hospital-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the safety committee. Based on document review and interview, it could not be determined the facility completed its process to evaluate</p>	S 1180	410 IAC 15-1.5-8 (f) (1) S1180 -Physical Plant- It could not be determined the facility	07/08/2016			

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	<p>and collect information about hazards and safety practices to be reviewed by the safety committee in 2 of 2 instances.</p> <p>Findings include:</p> <p>1. Review of a document entitled ENVIRONMENTAL TOUR - CLINICAL AREA WOMEN'S - 3rd FL., indicated the following categories:</p> <p>FIRE SAFETY PHYSICAL INSPECTION SAFETY MANAGEMENT PHYSICAL INSPECTION UTILITIES PHYSICAL INSPECTION INFECTION CONTROL PHYSICAL INSPECTION HAZARDOUS MATERIALS & WASTE PHYSICAL INSPECTION SECURITY PHYSICAL INSPECTION MEDICAL EQUIPMENT PHYSICAL INSPECTION, STAFF KNOWLEDGE QUESTIONS</p> <p>2. Further review of the WOMEN'S - 3rd FL document indicated there were multiple line item observations to be conducted under each category.</p> <p>3. Further review of the WOMEN'S - 3rd FL document indicated none of the</p>		<p>completed its process to evaluate and collect information about hazards and safety practices to be reviewed by the safety committee. (Environmental Tour-Clinical Area form had some categories with missing entries) Corrective Action(s): On or before July 8, 2016, the Environmental Tour- Clinical Area form was reviewed and revised to be more user friendly and to help ensure that all items are addressed and not inadvertently missed during rounds. Beginning in July 2016, on the Monday of the last work week of the month, the Senior Safety Officer will review all filed reports for completeness against the EOC Off-Site Rounds schedule and note any discrepancies. Any discrepancies against the schedule will be addressed so any missed rounds will be completed as scheduled. On or before July 8, 2016, the Safety Officer or his designee educated the multidisciplinary team members who conduct Environment of Care rounds about the revised form and answered any questions or concerns they had. Responsible Person(s): The Safety Officer and his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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	<p>above-stated categories and line items had any entry.</p> <p>4. Review of a document entitled ENVIRONMENTAL TOUR - CLINICAL AREA, DIGESTIVE HEALTH, indicated the following categories:</p> <p>FIRE SAFETY PHYSICAL INSPECTION SAFETY MANAGEMENT PHYSICAL INSPECTION UTILITIES PHYSICAL INSPECTION INFECTION CONTROL PHYSICAL INSPECTION HAZARDOUS MATERIALS & WASTE PHYSICAL INSPECTION SECURITY PHYSICAL INSPECTION MEDICAL EQUIPMENT PHYSICAL INSPECTION, STAFF KNOWLEDGE QUESTIONS</p> <p>5. Further review of the DIGESTIVE HEALTH document indicated there were multiple line observations to be conducted under each category.</p> <p>6. Further review of the DIGESTIVE HEALTH document indicated the section labeled FIRE SAFETY PHYSICAL INSPECTION had 6 of 8 line items</p>			

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S 1186 Bldg. 00	<p>entries and no other categories/line items had any entries.</p> <p>7. Interview of employee #A11, Safety/Emergency Management Officer, on 05-18-2016 at 12:15 pm, confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</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>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with NFPA (National Fire Protection Association)</p>	S 1186	410 IAC 15-1.5-8 (f) (3) (A) (B) (C)(D) (E) (i) (ii) (iii)(iv) (v) S 1186 -Physical Plant- Facility failed to conduct fire drills in accordance with NFPA.	07/08/2016

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	<p>Life Safety Codes, in 3 of 16 instances.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of NFPA 101 Life Safety Code, 2000 Edition, indicated fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. 2. In interview, on 05-118-2016 at 12:15 pm, employee #A11, Safety/Emergency Management Officer, indicated there were 2 shifts each at the main hospital and OS25 (St. Vincent Stress Center) offsite. 3. Review of fire drills conducted at the main hospital for calendar year 2015, indicated there were no fire drills conducted for the second shift of the 4th quarter. 4. Review of fire drills conducted at the OS25 for calendar year 2015, indicated there were no fire drills conducted for the first shift of the 1st quarter and the second shift of the fourth quarter. 5. Interview of employee #A11 on 05-18-2016 at 12:15 pm, confirmed all the above and no other documentation was provided prior to exit. 		<p>Corrective Action(s): On or before July 8, 2016 fire drill reporting template was revised and staff were educated on the new format. Further a 2016 Medxcel Fire Drill Report book was created to be kept in the Medxcel Facilities Maintenance library where a paper copy of all fire drills will be kept. Additionally, aSVIH 2016 Fire Drill Folder was created on the Medxcel FM "S" drive to keep an electronic copy of all fire drills. On July 6, 2016 training was conducted with the Safety Officer Team on the process of scanning the fire drills and filing them electronically to the "S" drive, as well as filing the paper fire drills in Medxcel FM library within twenty-four hours of conducting the drill. Monitoring: Beginning in July 2016, on the Monday of the last work week of the month, the Senior Safety Officer will review all filed reports against the Fire Drill monthly schedule and note any discrepancies. Any discrepancies against the schedule will be addressed so any missed drills will be completed as scheduled.</p> <p>Responsible Person(s): The Safety Officer and his designee will monitor these corrective actions to ensure the deficiency is corrected and will not recur.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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