

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/15/2014
NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303		
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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005079</p> <p>Survey Date: 1-13-14 to 1-15-14</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Steve Poore, BS MLT Medical Surveyor 3</p> <p>QA: claughlin 01/24/14</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 personnel file review and interview, the governing board failed to ensure the orientation and annual competency for blood administration for 4 of 4 contracted dialysis nurses (staff members N1 through N4).</p> <p>Findings: 1. at 10:55 AM on 1/14/14, review of contracted dialysis nurse employee files indicated: a. nurse N1 was hired 9/12/83 b. nurse N2 was hired 4/30/12 c. nurse N3 was hired 10/18/04 d. nurse N4 was hired 12/30/10 e. none of the four nurses had documentation in their personnel files of orientation, or annual competency, related to blood administration</p>	S000308	The 4 contracted dialysis nurses completed the blood administration competency on 1/15/2014. Contract staff files will be reviewed for completion of all required competencies during the annual competency review for non-contract staff. The Administrative Director Surgical Services is responsible for assuring completion of all required competencies by contracted dialysis staff. The deficiency was corrected on 1/15/14.	01/15/2014			

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S000394	<p>2. interview with staff member #66, a member of the quality/risk staff, at 10:25 AM on 1/15/14, indicated:</p> <p>a. nursing staff, including dialysis nurses, are required to complete annual education and competency related to blood administration</p> <p>b. nurses must have a "learning task assigned" (in the computer system) by educators that alerts them to required education modules that are available for them to complete</p> <p>c. the manager of the dialysis nursing unit is new in the last few months and may not know to coordinate with an educator to have learning tasks assigned</p> <p>d. it seems there was "missed communication" with the educators regarding orientation and annual competency related to blood administration for dialysis nursing staff</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and</p>	S000394	Seven of the eight providers not	01/29/2014			

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	<p>interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided, for 8 contracted services.</p> <p>Findings:</p> <p>1. On 1-13-14 at 1500 hours, a list of contracted services was received from staff A7. The list of services failed to indicate a service provider for air exchange certification, endoscopes, endoscope reprocessing, fire extinguishers, linear accelerator maintenance, magnetic resonance imaging (MRI) equipment maintenance, medical physics calibration and certification, and minimally invasive surgery instrumentation.</p> <p>2. Review of facility documentation indicated the following: air exchange certification by CS1, endoscope service by CS2, endoscope reprocessing equipment service by CS3, 2 fire protection services by CS4, linear accelerator service by CS5, MRI service by CS6, medical physics by CS7, and minimally invasive surgery instrumentation service by CS8.</p> <p>3. On 1-13-14 at 1515 hours, director of radiology A12 confirmed the list of contracted services failed to indicate a</p>		<p>on the Hospital Service Contract list at the time of survey have been added to the contract list. The eight provider ( Linear Accelerator Maintenance) is now provided internally by the hospital Biomedical Engineering Staff and is not longer a contracted service. The Contract Administration Policy has been revised to expand the definition of a Hospital Service Contract and Hospital Administrators responsible for Hospital Service Contracts are providing the quality performance metrics currently being tracked (at least 2), which is added to the contract list. Hospital Service Contract quality review thereafter to the Board of the Directors through the Hospital's quality assessment and improvement program. The Contract Coordinator is responsible for maintaining the Hospital Service Contract list, which is sent out monthly to Hospital Administrators for review and validation of accuracy. The Contract Coordinator reports to the Vice President and General Counsel who is responsible for oversight. The Administrative Director for Quality &amp; Safety is responsible for the quality assessment and improvement program and reporting through established quality structures the quality assurance data and directing change that will result in improvement. The Administrative Director Quality &amp; Safety reports</p>				

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S000608	<p>provider for medical physics and MRI services.</p> <p>4. On 1-14-14 at 1645 hours, contract coordinator A20 confirmed the list of contracted services lacked a provider for fire extinguishers, endoscope reprocessing, linear accelerators, medical physics and MRI services.</p> <p>5. On 1-15-14 at 1325 hours, performance improvement coordinator A8 confirmed the list of contracted services failed to indicate a provider for endoscopes, endoscope reprocessing, and minimally invasive surgery instrumentation.</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.</p>		to the Chief Medical Officer who is responsible for oversight. Date of Correction - 1/29/14				

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	<p>Based on policy and procedure review, observation, and staff interview, the infection control committee failed to ensure the implementation of its policy related to surgical masks and dangling earrings.</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Dress Code Policy For Perioperative Areas", File number "ICP-7.2-P", with a revision date of 5/22/12, indicated:</p> <p>a. under "Policy", it reads: "Personnel will follow dress code to promote high-level cleanliness and hygiene. AREA: Main Surgery, PACU (post anesthesia care unit),...Cardiac Cath Lab..."</p> <p>b. on page two under "Policy", it reads in section G.: "...3. When removing the mask, handle by strings only and discard immediately. Masks should not be left hanging around neck or tucked into pocket..."</p> <p>c. on page three under section K. and L., it reads: "All personnel entering the restricted and semi-restricted areas of the surgical suite will do the following:...4. Pierced earrings (no larger than 1 inch) will be confined under a cap. L. Personnel in un-restricted areas:...3. Pierced earrings (no larger than 1 inch.)..."</p>	S000608	The Perioperative Dress Code Policy was reviewed by all perioperative staff including staff from invasive procedure areas and the Anesthesia Medical Staff. Monitoring for continued compliance will be conducted daily by staff in those areas and monthly during external compliance audits. The Surgical Nurse Manager and Cardiac Catheterization Lab Nurse Manager are responsible for ongoing compliance with the dress code policy. The Director of Anesthesia Services is responsible for physician compliance. Plan of correction completed 1/21/2014.	01/21/2014

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	<p>2. at 9:30 AM on 1/14/14, while on tour of the PACU with staff member #72, the PACU nurse manager, it was observed that the anesthesiologist entered the area with a surgical patient and had their surgical mask dangling around the neck</p> <p>3. at 10:20 AM on 1/14/14, while on tour of the cardiac cath lab in the company of staff member #73, the cath lab charge nurse, it was observed that this staff member had earrings that dangled 2 to 3 inches that were not covered by their bouffant/surgical cap</p> <p>4. at 10:40 AM on 1/14/14, while exiting the surgery area, it was observed that staff member #81, a CST (certified surgical technician), was walking in the outer core with two other staff members (near the women's dressing room) with their surgical mask dangling about the neck</p> <p>5. at 2:30 PM on 1/15/14, interview with staff members #61, the PI (performance improvement) coordinator, and #65, the team leader of quality and risk, indicated the facility policy states that:</p> <p>a. surgical masks are not to be found dangling about the neck</p> <p>b. earrings are to be covered by the surgical hat/cap</p>						

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 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 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 policy and procedure review, observation, and interview, the nursing administrator failed to ensure the implementation of policies related to</p>	S000912	1. Appropriate expiration dating of multidose vials and glucometer reagents was reviewed with all staff involved in this process. The Nurse Managers of	01/31/2014

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	<p>glucometer control solutions, opened multi dose vials, and the cleanliness of storage areas.</p> <p>Findings:</p> <p>1. review of the policy and procedure "Point of Care Testing Services Whole Blood Glucose by Accu-Chek Inform II", procedure number 01.040.01H, with an approval date of 10/1/13, indicated:</p> <p>a. on page 3 under section "B. Reagents", it reads: "2...b...c. The date the vial is opened must be written on the vial label as well as the 3 month discard date. Open date (O: mm/dd/yy) and discard date (D: mm/dd/yy)."</p> <p>2. review of policy and procedure "Expiration Dates of Opened Multi-dose Vials and Large volume Intravenous Solutions", File number "PNS-11-P", with a revision date of 6/29/12, indicated:</p> <p>a. under "Policy", on page one, it reads: "I. Multiple-dose vials (i.e. vials containing a bacteriostatic agent) will be labeled with the new expiration date (28 days or less) and initials of the individual who opened the vial..."</p> <p>3. review of the policy and procedure "Cleaning Hospital Equipment", file number "NSP-58-P", with a revision date of 3/22/12, indicated:</p>		<p>all areas who handle multidose vials and glucometer reagents are responsible for ongoing compliance. Nurses on each unit who are assigned to the monthly expiration date are responsible for assuring that all items are correctly dated and to remove all items at time of expiration. Random spot checks conducted by external auditors are conducted monthly through the external auditing/tracer process. Plan of Correction Completed 1/31/2014</p> <p>2. The necessity to maintain all portable carts free from dust was reviewed with all unit staff. The Nurse Managers of all areas with portable carts are responsible for ongoing compliance. Staff on units who are assigned daily cleaning responsibilities are responsible for assuring that all portable carts are free from dust. Random spot checks conducted by external auditors are conducted monthly through the external auditing/tracer process. Plan of correction completed 1/31/2014</p>				

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	<p>a. on page two under "Clean Utility Room (CUR):", it reads: "...The following is done by Patient Care staff (nursing):...Portable carts for dressing changes, isolation supply storage, etc. are to be kept clean and stocked by the Patient Care Staff."</p> <p>4. at 10:40 AM on 1/13/14, while on tour of the pediatric unit in the company of staff member #61, the PI (performance improvement) coordinator, it was observed that the glucometer control solutions were dated with an expiration date of 60 days instead of 3 months (90 days), as per policy</p> <p>5. at 9:15 AM on 1/14/14, while on tour of the SAU (surgical assessment unit), in the company of staff member #61, the PI coordinator, it was observed that the glucometer solutions lacked notation of the 3 month expiration date</p> <p>6. at 2:05 PM on 1/14/14, while on tour of the labor and delivery area with staff member #61, the PI coordinator, it was observed that the glucometer control solutions were marked with an opened date, but lacked notation of the 3 month expiration date</p> <p>7. interview with staff member #61 indicated that the glucometer control</p>						

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	<p>solutions as found in 3, 4., and 5., above were not marked as per facility policy</p> <p>8. at 2:45 PM on 1/13/14, while on tour of the CCU (coronary care unit) in the company of staff member #70, the nurse manager of the unit, it was observed in the storage room that the portable cart the comfort bath warmer was sitting on had a large accumulation of dust on all three shelf units of the cart</p> <p>9. at 2:55 PM on 1/13/14, while on tour of the CCU in the company of staff member #70, the nurse manager of the unit, it was observed in room 26 that a 30 ml vial of 0.9% NACL (sodium chloride) was opened, but not dated with a 28 day expiration date, or an initial of the staff member who opened it</p> <p>10. interview with staff member #70 at 2:45 PM and 2:55 PM on 1/13/14 indicated:</p> <p>a. the portable cart in the storage room should not have had such a large accumulation of dust present in a clean storage area</p> <p>b. the NACL vial in room #26 should have been dated when opened with the 28 day expiration date, and should have been initialed by the staff member who</p>						

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S001118	<p>opened it</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on policy and procedure review, document review, manufacturer recommendation review, observation, and interview, the facility failed to ensure that a condition was not created that might be a hazard to patients, employees, or visitors related to expired lab tubes, dusty blanket warmers, blanket warmers/fluid warmers at too high a temperature, and a dirty comfort bath warmer and failed to follow its policy/procedure and assure that biohazardous waste did not present a potential hazardous condition for personnel and the public in one instance.</p> <p>Findings: 1. review of the policy and procedure "Commercial Basin-less Bath Product", file number "NSP-68-P, with revision</p>	S001118	<p>1. A policy related to blanket and fluid warmers has been developed, distributed and implemented and communicated to all staff who utilize warmers. The warmer temperature monitoring form was revised to reflect the appropriate ranges for both blankets and fluids. The warmers without temperature dials were removed from use. All warmers in use have built in temperature gauges. The nurse managers of the areas where warmers are in use are responsible for the appropriate temperature monitoring and the removal of outdated fluids from the cabinets. Staff in each area are assigned to the daily monitoring and recording of temperatures. Random audits are conducted during the monthly audit/tracer activities by external auditors. The Plan of Correction</p>	01/31/2014			

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	<p>dates of 3/30/11 and 6/23/11, indicated:</p> <p>a. in the "Scope/Categories" section, it reads: "IU Health Ball Memorial Hospital Nursing Oncology"</p> <p>b. under "Policy:", it reads: "All patients who are to be bathed in bed or at the bedside on the Oncology Unit have the option to be bathed using the commercial basin-less bath product..."</p> <p>2. at 2:45 PM on 1/13/14, while on tour of the CCU (coronary care unit) in the company of staff members , #61, the PI (performance improvement) coordinator and #70, the nurse manager of the unit, it was observed that:</p> <p>a. a comfort bath warmer was located in the clean utility/equipment storage area</p> <p>b. the interior of the unit had debris on the shelf units</p> <p>3. interview with staff member #70 at 2:45 PM on 1/13/14 indicated:</p> <p>a. the comfort bath product was used for open heart patients</p> <p>b. the interior of the warmer was dirty</p> <p>4. interview with staff member #61 at 1:20 PM on 1/14/14 indicated it was unknown why the CCU area wasn't listed in the policy and procedure for the basin-less bath product if they are approved to have the item/product in</p>		<p>was completed by 1/31/2014 2. The process for regulated waste has been revised to require all waste to be collected, weighed and immediately taken to the regulated waste storage trailer which is designated as secure and appropriate storage. All staff involved in the collection and disposal of regulated waste have been apprised of this changed process. The Environmental Services Manager is responsible for on-going compliance. Random audits are conducted during monthly audit/tracer activities by external auditors. The Plan of Correction was completed by 1/15/14</p>				

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	<p>their area</p> <p>5. at 11:40 AM on 1/13/14, while on tour of the 7 North general surgery nursing unit in the company of staff member #61, the PI coordinator, and #64, the nurse manager of the unit, it was observed that the blanket warmer in the clean utility room was dusty on the lower shelf (of the bottom cabinet)</p> <p>6. at 9:20 AM on 1/14/14, while on tour of the SAU (surgery assessment unit) in the company of staff members #61, the PI coordinator, and #72, the nurse manager, it was observed that :</p> <p>a. the Getinge blanket warmer was dusty on the lower shelf</p> <p>b. the "Warming Cabinet Monitoring" document indicated temps for January 2014 ranged from 119 to 124 degrees, but the form indicates that temperatures are not to exceed 110 degrees</p> <p>7. at 9:35 AM on 1/14/14, while on tour of the endoscopy pre/post op area in the company of staff member #72, the nurse manager, it was observed in a storage cabinet that two pink top lab tubes had expired 8/13</p> <p>8. interview with staff member #65, the team leader of quality and risk, at 4:00 PM on 1/14/14 indicated there is no</p>			

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	<p>policy or procedure related to:</p> <ul style="list-style-type: none"> <li>a. the cleaning of blanket warmers</li> <li>b. the checking of outdated supplies on the nursing units</li> </ul> <p>9. at 3:40 PM on 1/14/14, review of the manufacturer's information related to "Sodium Chloride Injection, USP in Viaflex plastic container", indicated:</p> <ul style="list-style-type: none"> <li>a. on page 4 it reads: "Exposure of pharmaceutical products to heat should be minimized. Avoid excessive heat. It is recommended the product be stored at room temperature (25 degrees C/77 degrees F); brief exposure up to 40 degrees C (104 degrees F) does not adversely affect the product."</li> </ul> <p>10. at 3:40 PM on 1/14/14, review of the manufacturer's information related to "Lactated Ringer's Injection, USP in Viaflex Plastic Container", indicated:</p> <ul style="list-style-type: none"> <li>a. "Exposure of pharmaceutical products to heat should be minimized. Avoid excessive heat. It is recommended the product be stored at room temperature (25 degrees C); brief exposure up to 40 degrees C does not adversely affect the product."</li> </ul> <p>11. at 10:15 AM on 1/14/14, while on tour of the surgery area in the company of staff member #71, the surgery manager, it was observed that the Castle</p>						

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	<p>blanket warmer (#8) between operating rooms 3 and 4:</p> <ul style="list-style-type: none"> <li>a. had bottles of fluid in the top warming cabinet</li> <li>b. had blankets and bags of IV (intravenous) fluids in the bottom warming cabinet</li> <li>c. had no thermometers present in either cabinet to alert staff to the cabinet temperatures</li> <li>d. had dials set to approximately 120 degrees</li> </ul> <p>12. at 3:40 PM on 1/14/14, it was reported that maintenance staff checked the cabinet temperatures for the Castle (#8) blanket warmer listed in 11. above and found that the top cabinet temp was 116 degrees and the lower cabinet temp was 110 degrees</p> <p>13. at 4:00 PM on 1/14/14, interview with staff member #65, the team leader of quality and risk, indicated:</p> <ul style="list-style-type: none"> <li>a. there is no policy and procedure related to blanket warmer and/or fluid warmer temperatures</li> <li>b. there are "warming cabinet monitoring" forms (with a date of 11/12/13) on most facility warming cabinets that indicate a 110 degree reading is not to be exceeded</li> <li>c. there is a facility form dated 1/29/13 for documenting fluid warmers which</li> </ul>						

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	<p>indicates that 104 degrees is the maximum temperature for fluids</p> <p>d. the Castle warmer in the surgery area was found to be too warm for the fluids contained within since 116 and 110 degrees was noted when facility maintenance staff checked the temperatures of the cabinets this afternoon and the manufacturer recommends a temperature of no higher than 104 degrees for fluids</p> <p>14. The policy/procedure General Infection Prevention Practices for IU Health Ball Memorial Hospital (approved 3-12) indicated the following: " Regulated waste must not be transported or stored with routine waste/trash or laundry ... gloves are not necessary when pushing the regulated waste cart to the regulated waste holding room ... hands must be washed after transporting waste ... regulated waste shall be stored in a secure area labeled with a biohazard symbol, a [and] allowing no access to the public ... after handling regulated waste, hand hygiene must be performed ... "</p> <p>15. During a tour on 1-13-14 at 1245 hours, in the presence of staff A8, A15 and A16, the following condition was observed in a basement room of the facility: three unsecured red regulated waste totes on top of a pallet adjacent to</p>						

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	<p>7 empty stacked red totes in the room including a cardboard compactor and adjacent to a secured area containing pharmacy waste. The far end of the room was open and included a vinyl finger curtain allowing unrestricted access to a parking area with a semi-trailer for storage of the regulated medical waste containers until transported to a registered facility for processing. No handwashing sink or hand sanitizer was observed in the area including the regulated waste totes.</p> <p>16. During an interview on 1-13-14 at 1245 hours, staff A15 indicated that the totes were only present temporarily until moved on to the medical waste storage trailer.</p> <p>17. During a tour on 1-14-14 at 1455 hours, in the presence of staff A5 and A21, the following condition was observed in a basement room of the facility: two unsecured red regulated waste totes on top of a pallet adjacent to 5 empty stacked red totes in the room including a cardboard compactor. The far end of the room was open and no handwashing sink or hand sanitizer was observed in the area including the regulated waste totes.</p> <p>18. During an interview on 1-14-14 at</p>			

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S001172	<p>1455 hours, EVS staff A27 indicated that every day the regulated waste totes are accumulated on the pallet and eventually transported out to the trailer.</p> <p>19. During an interview on 1-14-14 at 1455 hours, staff A5 confirmed that the area was not secure if no staff were present.</p> <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 policy and procedure review, document review, observation, and interview, the facility failed to ensure the cleanliness of pantry refrigerators.</p> <p>Findings: 1. review of the policy and procedure</p>	S001172	The Policy for Cleaning Hospital Equipment which includes weekly cleaning of patient pantry refrigerators and the documentation of such was reviewed with all environmental services staff. The Manager of Environmental Services is responsible for the ongoing	01/20/2014			

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	<p>"Cleaning Hospital Equipment", file number "NSP-58-P", with a revision date of 3/22/12, indicated:</p> <p>a. on page 3 under "Kitchen/Pantry", it reads: "The following is done by Environmental Services:... Weekly: Inside of refrigerator and inside of microwave..."</p> <p>2. at 11:35 AM on 1/13/14, while on tour of the 7 North, General Surgery nursing unit in the company of staff member #64, the nurse manager of the unit, it was observed that the pantry refrigerator freezer shelf had food debris present, the refrigerator was dirty under the vegetable drawers, and the glass shelf covering the vegetable drawers was dirty where it made contact with the drawers</p> <p>3. at 11:35 AM on 1/13/14, review of the posted "Refrigerator Weekly Cleaning Schedule for Patient Care Areas Sunday Checklist" for the "7 North Surgical" unit indicated:</p> <p>a. the refrigerator (listed in 2. above) was cleaned at 8:50 AM on 1/12/14</p> <p>b. no cleaning was done on 1/5/14, as policy indicates is to be accomplished</p> <p>c. 3 weeks of cleaning did not occur in 2013 (4/7/13, 4/21/13, and 12/22/13)</p> <p>4. at 2:10 PM on 1/13/14, while on tour</p>		<p>compliance with this policy. The need to dispose of patient food items upon discharge/transfer of the patient from the unit was reviewed with Nursing staff. The Nurse Manager is responsible for ensuring with compliance. Random audits are included during the monthly audit/tracers conducted by external auditors. Plan of Correction Completed 1/20/14</p>				

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	<p>of the CIC (coronary intensive care unit), in the company of staff members #68, the CIC nurse manager, and #67, the charge nurse, it was observed that the following food items were labeled for 5 patients no longer in the CIC:</p> <ul style="list-style-type: none"> <li>a. chocolate pudding dated 12/15/13</li> <li>b. two subway sandwiches dated 1/3/14</li> <li>c. soup dated 12/5/13</li> <li>d. evening snacks for two patients dated 1/7/13 and 1/8/13</li> </ul> <p>5. at 2:10 PM on 1/13/14, review of the posted "Refrigerator Weekly Cleaning Schedule for Patient Care Areas Sunday Checklist" for the CIC indicated:</p> <ul style="list-style-type: none"> <li>a. the refrigerator was last noted as cleaned at 8:13 AM on 1/12/14</li> </ul> <p>6. interview with staff members #67 and #68 indicated it was unknown whose responsibility it was to remove food items for patients no longer in the CIC--housekeeping staff clean the refrigerator once a week and dietary restocks the refrigerator, but no one is monitoring the refrigerator for patient items for those no longer a patient in the unit</p> <p>7. at 2:50 PM on 1/13/14, while on tour of the CCU (coronary care unit) in the company of staff member</p>						

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	<p>#70, the nurse manager of the unit, it was observed that the pantry refrigerator had a sticky substance on the 2nd shelf, had crumbs and debris under the vegetable drawers, and had a piece of cake present that was for a patient who had been discharged and was no longer at the facility</p> <p>8. at 3:20 PM on 1/14/14, while on tour of the psych II nursing unit in the company of staff member #61, the PI (performance improvement) coordinator, it was observed that the pantry refrigerator had crumbs under the vegetable drawers and the glass shelf covering the vegetable drawers was dirty where it made contact with the drawers</p> <p>9. at 3:30 PM on 1/14/14, while on tour of the psych II nursing unit in the company of staff member #61, the PI coordinator, it was observed that the small refrigerator in the nursing station area was dirty on the shelves of the door and the bottom of the refrigerator (hair, dried liquid, and debris noted)</p> <p>10. interview with staff member #61, the PI coordinator, while touring the nursing units listed above, indicated that it cannot be determined what the environmental services cleaning process consists of for the pantry refrigerators,</p>			

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	as they were not clean the next day when observed by staff			