

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151307	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
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NAME OF PROVIDER OR SUPPLIER ST VINCENT WILLIAMSPORT HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 412 N MONROE ST WILLIAMSPORT, IN 47993
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 5/14/2013 through 5/15/2013</p> <p>Facility Number: 005092</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 05/23/13</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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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure 8 services were part of its quality assessment and improvement (QA&I) program: CT Scanner, Dietetic Services, Endoscopy, Infusion Therapy, Mammography, Orthopedic Surgery, Ultrasound, and Social Services.</p> <p>Findings included:</p> <p>1. St. Vincent Williamsport Hospital Quality Improvement Plan (Organizational Improvement Plan - last approved 2/2011) implements</p>	S000406	<p>S 0406 1. The Organizational Improvement Plan last approved date is 01/2013. No revisions were made January 2013. Last revisions were 1/2011. 2. CT scanner, Dietetic Services, Endoscopy, Infusion Therapy, Mammography, Orthopedic Surgery, Ultrasound, and Social Services quality reviews have been added to the hospital quality assessment and improvement program. SVW Radiology Manager will be responsible for the data collection and summarization of Mammography, CT scanner, and Ultrasound. SVW Pharmacy Manager will be responsible for the data collection and summarization of Infusion therapy. Discharge Planning is responsible for data collection and summarization for Social Services. SVW Medical / Surgical Manager will be</p>	05/30/2013			

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	<p>all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p> <p>2. The hospital Quality Improvement Program was reviewed with staff member #2 on 5/15/2013. Eight services the hospital provides were not part of the quality assessment and improvement program. The eight services were CT Scanner, Dietetic Services, Endoscopy, Infusion Therapy, Mammography, Orthopedic Surgery, Ultrasound, and Social Services.</p> <p>3. At 2:45 PM on 5/15/2013, staff member #2 indicated he/she does not have documentation supporting the eight services were being monitored and evaluated as part of its Quality Improvement Program: (CT Scanner, Dietetic Services, Endoscopy, Infusion Therapy, Mammography, Orthopedic Surgery, Ultrasound, and Social Services)</p>		<p>responsible for the data collection and summarization of Dietary services. SVW Surgery Manager is responsible for data collection and summarization related to Orthopedic Surgery and Endoscopy. Reports will be given to the Quality Manager for reporting to Quality Council for review, analysis, and if needed development of strategies to improve our performance to achieve good outcomes.3. SVW Quality Manager will be responsible for ensuring data is collected, summarized, analyzed, and reported.</p>				

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, manufacturer's directions, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage and by following manufacturer's directions.</p> <p>Findings included:</p> <p>1. During the tour of the Medical/Surgical Unit at 12:30 PM on 05/14/13, accompanied by staff members A3 and A17, the following observations were made:</p> <p>A. Two of two bottles of Accucheck glucometer control solutions, open, but not dated. Manufacturer's directions were to date when opening and discard after 90 days.</p> <p>B. Four of four pink-topped lab tubes with an expiration date of 04/2013 in the clean utility room.</p> <p>C. Three of three Ranger Blood/Fluid Warming Tubing with an expiration date of 11/2012 in the med room.</p> <p>D. Four of four Advance Plus Safety IV Catheters, 24 gauge expired 07/2011, and</p>	S000554	<p>S 0554 1 A. On 5/15/2013 Medical/Surgical Unit two (2) bottles of Accucheck glucometer control solutions not dated were discarded and replaced with new dated bottles by the Medical/Surgical Department Manager. A bright colored sticky label with instructions to label Accucheck glucometer control solution with the date opened and discard the solution in 90 days was placed on the Accucheck case the solution is stored in. The Medical/Surgical day charge nurse is responsible for checking the solution to ensure the solution is dated and not beyond use date.</p> <p>B. On 5/15/2013 four (4) pink-topped lab tubes with expiration date of 4/2013 were removed and discarded from the clean utility room by the Medical/Surgical Department Manager. The Medical/Surgical day charge nurse is responsible for checking the lab tube dates to ensure the tubes are not beyond use date. C. On 5/15/2013 three (3) Ranger Blood/Fluid Warming tubing with an expiration date of 11/2012 were removed and discarded from the medication</p>	05/16/2013			

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	<p>four of four 20 gauge expired 11/2012 in the crash cart.</p> <p>2. During the tour of the Recovery Room at 1:55 PM on 05/14/13, accompanied by staff member A2, two of two bottles of Accucheck glucometer control solutions were observed dated 01/10/13- 04/10/13. Manufacturer's directions were to date when opening and discard after 90 days.</p> <p>3. During the tour of the Emergency Department at 9:20 AM on 05/15/13, accompanied by staff member A3, the following expired items were observed in the trauma room crash cart:</p> <p>A. Advance Plus Safety IV Catheters, three of four 20 gauge expired 12/2012.</p> <p>B. Advance Plus Safety IV Catheters, five of five 22 gauge expired 10/2012.</p> <p>C. Advance Plus Safety IV Catheters, three of four 18 gauge expired 10/2011.</p>		<p>room. Ranger Blood/Fluid warming tubing will be kept with the machine not stored on shelves in the medication room. The perioperative nurse staffing the recovery area where the Ranger Blood/Fluid warming machine is stored will be responsible for ensuring tubing is with the machine and not beyond use date. D. On 5/15/2013 four (4) Advance Plus Safety IV Catheters 24 gauge and four (4) 20 gauge IV catheters were removed, discarded, and replaced from the crash cart by the Medical/Surgical Department Manager. The Medical/Surgical day charge nurse will assign a nurse to check the crash cart each day for outdates. 2. On 5/15/2013 two (2) bottles of Accucheck glucometer control solutions dated improperly and outdated were discarded and replaced with new dated bottles by the recovery room nurse. A bright colored sticky label with instructions to label Accucheck glucometer control solution with the date opened and discard the solution in 90 days was placed on the Accucheck case the solution is stored in. The recovery room nurse is responsible for checking the solution to ensure the solution is dated correctly and not beyond use date. The Surgery Manager placed a memo in her automated calendar to alert her in 90 days to check the solution and ensure the solution was replaced. 3. On</p>		

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			5/15/2013 three (3) 20g Advance Plus Safety IV catheters, five (5) 22 g Advance Plus Safety IV catheters, and three (3) 18g Advance Plus Safety IV catheters beyond use date were removed, discarded, and replaced from the trauma room crash cart by our CNO. The ED Charge nurse is responsible for checking the crash cart daily for outdates.4. SVW Chief Nursing Officer will be responsible for ensuring supplies are checked for outdates and manufacturer's directions are followed.		

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S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation.</p> <p>Based on observation, the facility failed to maintain sanitary conditions of a cabinet located in the CT Scanner room.</p> <p>Findings included:</p> <p>At 11:50 AM on 5/15/2013, the CT Scanner room was toured. The end cabinet with a sink basin on the end of the counter was inspected. Under the sink was a bag containing Dispatch cleaner. The clear bag was wet on the outer surface and appeared to be leaking on the cabinet lower shelf. The</p>	S000592	S 0592 On 5/15/2013 all items under the sink cabinet in the CT Scanner room were removed by the Plant Operations Manager and the cabinet was sealed shut. To ensure sanitary conditions are maintained under sink storage inspection will be included as part of our risk assessment rounds conducted by Safety Officers and Department Managers (no less than 2 times/year) with results reported to Health and Safety Committee. All Radiology associates were informed by the Infection Control Officer that no items are to be stored under sink cabinets to ensure sanitary conditions. A hospital wide e-mail was sent to each individual informing everyone our policy is to not store anything under sink cabinets.SVW Safety Officer will	05/16/2013

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	cabinet was also storing 5 containers of PDI Sani-wipes disinfectant. Two of the containers were stored on lids of gallon latex paint cans that had excess paint on the outside of the cans. One container of PDI Sani-wipes was observed with a heavy accumulation of liquid spots that dried to a whitish color. The sani-wipes and dispatch were also stored under the faucet's drain pipes.		responsible for monitoring sanitary conditions related to under sink storage.	

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation and interview, the facility failed to ensure chemical Cidex OPA was used according to the manufacturer's recommendations in the Ultrasound Room and failed to ensure policies and procedures were in place and followed for the disinfection of instruments in the Surgical Department.</p> <p>Findings included:</p> <p>1. St. Vincent Williamsport Hospital Hazardous</p>	S000596	<p>S 0596 1. On 5/20/2013 the Radiology Manager updated the Ultrasound Probe Cleaning policy. In the policy it states "the Ultrasound Technologists will use gloves, goggles, and gown during this procedure for personal protection. A supply of gloves, gowns, goggles, and shoe covers shall be maintained in the Ultrasound room." The Radiology Manager reviewed the policy with the Ultrasound Technologists and all the radiology associates. Each associate was given a copy of the policy. The Ultrasound Technologists are responsible for maintaining a supply of PPE in the Ultrasound room. 2. On 5/20/2015 the Radiology Manager replaced the Chemical Cidex OPA with MetriCide Plus 30. The Ultrasound Probe Cleaning policy</p>	05/22/2013

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	<p>Communication Plan policy #150278 (last reviewed 2/2012) indicates staff must comply with the manufacturer's recommendation on the use of any chemical. The staff are required to utilize personal protective equipment when required: gloves, aprons, goggles.</p> <p>2. Cidex OPA manufacturer sheet requires: 1) The user should be adequately trained in the demonstration and disinfection of semi-critical medical devices and the handling of liquid chemical germicides, 2) Once opened, the unused portion of the solution may be stored in the original container up to 75 days until used, 3) Record the date the container was opened on the container label or in a log book, record the date the solution was poured outside the original container and the product must be used within 14 days, 4) Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each</p>		<p>was updated to reflect the change. Included in the policy is the 90 minute soaking time and 3 separate immersions in large volumes of water. The date of activation and expiration date is recorded in the Ultrasound log book. 3. On 5/15/2013 The Radiology Manager found Personal protective equipment (gloves, eye protection, face masks and liquid proof gowns) in the Ultrasound room in the file cabinet. It had been moved to this location by the Ultrasound Technologist to create more room for other supplies in the built in cabinets. The Ultrasound Technologists are responsible for maintaining a stock of PPE in the room to wear when cleaning the ultrasound probe or changing the solution. Ultrasound Technologist # 2 stated she had mistakenly left the caps off the container and this was not her normal practice. The Ultrasound Technologists stated they understand the caps are to be on the containers all the time and are responsible for ensuring the caps are on the containers. MetriCide Plus 30 recommends a 1.8% glutaraldehyde concentration indicator be used to ensure the appropriate concentration of glutaraldehyde is present. MetriTest a 1.8% glutaraldehyde concentration monitor is being utilized to test the activated solution. The Ultrasound Technologist is responsible for ensuring the</p>				

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	<p>time should be done for a minimum of 1 minute. Always use fresh water each time this step is done 5) Use Personal Protective Equipment (PPE) when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns, and 6) the lids for the test strips and solution need to be tight fitting.</p> <p>3. At 12:10 PM on 5/15/2013, the Ultrasound Room was toured. The room lacked fluid resistant aprons and goggles for handling Cidex OPA. The test strips in the room to test the concentration of Cidex OPA were for another high-level disinfectant, Metricide. The 2 blue caps to the wall-mounted G14C Disinfection Soak System were not replaced on the two containers as required by the manufacturer when not in use.</p> <p>4. The St. Vincent Williamsport Ultrasound Cidex Solution Log for 2013 was reviewed. The log revealed the date the solution was activated and the date the solution</p>		<p>MetriTest 1.8% strips are being used and the lid is kept on the container. 4. On 5/20/2013 MetriCide Plus 30 log sheets were placed in the Ultrasound log book to document activation and expiration dates and concentration indicator results. MetriCide Plus 30 is reusable for 28 days. The Ultrasound Technologists are responsible for monitoring the activation and expiration dates of the solution and changing the solution as needed. 5 – 8. On 5/20/2013 Surgery changed products to MetriCide (Glutaldehyde 2.6%). A policy for MedtriCide was developed by the Surgery Manager and approved for use by Health and Safety Committee 5/23/2013 and Quality Council 5/31/2013. MetriCide can be used for sterilization (10 hour soak time) and high level disinfection (45 minute soak times) not to exceed 14 days. Rinsing instructions – immerse completely in three (3) separate copious volumes of water. Each rinse duration should be a minimum of one (1) minute. The Metricide OPA Plus poster was removed from the bulletin board in the surgery decontamination room and replaced with a copy of the MetriCide policy. Surgery CST associates were educated on the use of MetriCide and given a copy of the policy and product literature insert. Surgery CST associates are responsible for</p>				

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	<p>was to expire totaled 30-days. The date the container was opened and logged was 16 days longer that the required 14-days by the manufacturer of Cidex.</p> <p>5. During the tour of the decontamination room of the Surgical Area at 2:20 PM on</p>		<p>labeling containers, documenting activation dates and expiration date in log, and ensuring solution is changed at least every 14 days. Surgery CST's will utilized MetriTest a 1.5% glutaraldehyde concentration monitor strip to test the activated solution concentration and document results.SVW Surgery Manager is responsible for conducting spot checks to ensure manufacturer's recommendations are followed. On 6/26/2013 a spot check was conducted by the Surgery Manager. Surgery CST's were observed checking the Metricide container label dates and temperature of the solution prior to use and documenting on log. Date and temperature were within manufacturer's recommendation. A timer was set for 45 minutes when equipment was placed in solution. Manager returned to observe the timer signal and equipment removed from solution. Protective ware was utilized.On 7/1/2013 Surgery manager conducted a spot check on the Ultrasound tech. The tech was observed utilizing the Metricide according to manufacturer's recommendation checking label dates, temperature, and recording in log. Timer was set for the correct soaking time. Protective ware was utilized. A review of the log showed correct documentation.</p>		

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	<p>05/14/13, accompanied by staff member A2, two plastic containers labeled with Metricide and dated with a 28-day expiration date were observed on a shelf.</p> <p>6. At 2:20 PM on 05/14/13, staff member A19 indicated instruments were soaked in the container for 20 minutes then rinsed once in sterile water in a basin. He/she indicated the Metricide was changed every 28 days.</p> <p>7. Manufacturer's directions for the use of Metricide OPA Plus were taped on the wall of the decontamination room and indicated, " It may be reused for up to 14 days when monitored according to label instructions for use. ...Soak instruments in Metricide OPA Plus Solution for 12 minutes ...6. Rinsing Instruments- After manual processing- After removing the instrument from the Metricide OPA Plus Solution, thoroughly rinse the device by immersing it completely in a large volume (approx. 9 liters) of fresh water. ...Keep the instrument totally immersed for a minimum of one minute unless a longer time is specified by the instrument manufacturer. ...Repeat the procedure two additional times for a total of three rinses."</p> <p>8. Review of the facility's disinfecting policies failed to indicate policies and</p>			

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	procedures for the use of Metricide OPA.			

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S000610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on documentation review, observation, and staff interview, the facility failed to ensure the dietary procedures were in compliance with sanitation practices specified in 410 IAC 7-24, Retail Food Establishment Sanitation Requirements and hospital policies.</p>	S000610	S 0610 To ensure the dietary procedures are in compliance with 410 IAC 7-24 St. Vincent Williamsport (SVW) will be implementing the following procedures: 1. SVW associates will arrive at the vendor to receive meals at scheduled times for breakfast, lunch, and dinner. As the first tray is being filled the vendor will temp check the entrée, hot side, and cold side	06/13/2013

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	<p>Findings included:</p> <p>1. St. Vincent Williamsport Hospital Patient Meal's policy #279353 (last reviewed September 2011) requires the department to comply with local, state, and federal laws. The policy indicates proper hand washing practices will be followed. Any foods that integrity cannot be verified regarding expiration dates, contents, etc., shall be discarded immediately. Hot food shall be kept at the appropriate temperatures in accordance with 410 IAC 7-24. Time of pick-up from the contracted food vendor and delivery to the patients will be recorded by SVWH. The food shall be marked or otherwise identified to indicate that is 4 hours past the point in time when the food is removed from temperature control.</p> <p>2. Retail Food Establishment Sanitation Requirements Title 410</p>		<p>witnessed and documented by the SVW associate. The SVW associate will record the temperature on the appropriate form along with the time of the temperature and time of delivery to hospital. The time the trays are filled will be documented on the sticker attached to the tray with the patient's name as well as the form. The time the last tray is delivered to the patient will be recorded on the form. After the evening meal each day the completed form is placed under the Medical/Surgical Manager's door for review. Our hospital Dietician educated and all the hospital associates who will be responsible for transporting trays. Time was allowed for questions and comments. The revised process began on 6/5/2013. 2. The dietary policy "Patient Meals" was revised by the Medical/Surgical Manager and Dietician on May 31, 2013 to reflect the process change. 3. A mandatory dietary inservice is scheduled for June 13, 2013 for the Medical/Surgical department staff. The inservice will encompass the safe handling of patient's food, required temperatures for frozen meals, and techniques to take temperatures including appropriate sanitizing of the thermometer probe. Medical/Surgical Manager and Dietician will lead the inservice. 4. There will be a log placed in the</p>		

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	<p>IAC 7-24 effective November 13, 2004 states, " The person-in-charge of the retail food establishment shall ensure the following: Employees are visibly observing foods as they are received to determine that they are from approved sources, delivered at the required temperatures, protected from contamination, unadulterated, and accurately presented by routinely monitoring the employees' observations and periodically evaluating foods upon their receipt; Employees are preventing cross contamination of ready-to-eat food from unwashed hands; and Employees are properly trained in food safety as it relates to their assigned duties." The sanitation requirements indicate when time is used in lieu of temperature control, a written procedure must be approved by the regulatory authority.</p> <p>3. At 11:45 AM on 5/14/2013, the patient trays were observed being received on the receiving dock of</p>		<p>Medical/Surgical pantry to record the temperature of frozen meals after preparation. Frozen meals are to be heated to a temperature of 165°F. An infrared thermometer is available for checking the temperatures of the food. This will begin after the mandatory inservice on June 13, 2013.5. SVW Dietary Manager will be responsible for ensuring the dietary procedures are in compliance with 410 IAC 7-24 through periodic spot checks and monitoring.</p>	

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	<p>the hospital. The hospital staff picks up the patient trays from a nursing home. Staff member #9 was observed removing a thermometer from an utility drawer and tested the hot and cold food on the tray. The thermometer probe was not sanitized before the food temperatures were taken. The temperature of the cold food exceeded the 41 F requirement for cold holding. The temperature of the tuna fish salad and cottage cheese registered 72.5 and 66.5 F respectively. Staff member #10 was observed serving the trays to the patients without washing his/her hands; instead, the staff member was observed only using a hand sanitizer. The trays that were served to patients contained cold items that were not tested at 41 F or less. The patient trays were observed with names on them but no documentation when the food was removed from temperature control.</p> <p>4. At 12:35 PM on 5/14/2013, staff</p>			

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	<p>member #9 was observed preparing a frozen dinner in the microwave. The staff member was not wearing a hair restraint while preparing food for patients. The staff member was observed testing the food with a thermometer that was removed from an utility drawer without sanitizing the probe before it was used.</p> <p>5. The frozen dinners kept in the freezer indicated the internal temperature of the hot food needs to exceed 165 F before served.</p> <p>6. Three staff members that prepare the frozen dinners for the patients on 5/14/2013 were asked what was the temperature requirement after being heated in the microwave. At 12:35 AM, staff member #9 indicated the hot food must be at least 142 F. At 1:05 PM, staff member #10 indicated he/she does not take temperatures of the frozen food after it was removed from the microwave. The staff member</p>			

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	<p>indicated he/she does not know anything about the temperature requirements. At 1:10 PM, staff member #16 indicated he/she has never tested frozen dinners.</p> <p>7. At 1:00 PM on 5/14/2013, staff member #6 indicated the hospital follows a time control policy; however, the policy has never been approved by the regulatory authority as required by 410 IAC 7-24. The staff at the nursing home records the temperature when the food leaves the kitchen and provides it to the hospital once a month.</p>			

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S000612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling. Based on observation, the facility failed to store clean linen in a sanitary condition for the Clean Linen Storage Room.</p> <p>Findings included:</p> <p>At 12:00 PM on 5/15/2013, the Clean Linen Storage Room connected to the Ambulance Sleeping Quarters out-building was inspected. At the rear wall of the Clean Linen Storage Room was a linen storage rack lacking means for any type of covering. There were clean sheets on the rack. Located above the rack was a wall vent that connected the ambulance staff sleeping quarters to the clean linen storage. The vent was observed with heavy accumulation of dust, dirt, and other soil residue on it.</p>	S000612	S 0612 Touch Point Housekeeping Manager and Plant Operations Manager cleaned the vent of all dust, dirt, and soil following the tour on 5/15/2013. A permanent cover was placed over the clean sheet storage rack on 5/15/2013. Our Touch Point Housekeeping Manager reviewed linen management and the importance of storing clean linen in sanitary conditions with all the Touch Point Housekeeping associates. Our Touch Point Housekeeping Manager assigned the day shift housekeeping staff to dust and wipe down the vent at least once each week to keep it clean. Our TP Manager at least twice weekly will check the clean sheet storage rack to ensure it is covered and the vent is clean and report the	05/20/2013			

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			findings to our Health and Safety Committee.SVW Touch Point Housekeeping Manager is responsible for ensuring clean linen is stored in sanitary conditions.	

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S000748	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3). Based on review of the Medical Staff Rules and Regulations, medical record review, and interview, the facility failed to ensure all entries in the medical records were authenticated and dated according to facility requirements for 6 of 14 history and physicals (#N1, N3, N4, N9, N11, and N14), for 9 of 14 physician verbal/telephone orders (#N1, N2, N3, N4, N8, N9, N10, N11, and N14), and for 6 of 14 discharge summaries (#N2, N4, N8, N9, N11, and N14).</p> <p>Findings included:</p> <p>1. The facility's "Medical Staff Rules and Regulations", adopted December 2012 and approved January 2013, indicated, "9.10 All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated. ...9.20 The physician shall strive to have the patient's medical record complete at the time of discharge, including progress notes, final diagnosis and (dictated) clinical resume. ...9.22 A practitioner's charts will be considered delinquent at thirty (30) days.</p>	S000748	S 0748 On 5/20/2013 Medical/Surgical Manager, Discharge Planning Nurse, Medical/Surgical staff nurses and CNO began checking medical records after the physician completes rounds and before they leave the facility for orders or dictation not dated, timed, and signed. The charts are given back to the physician to complete the authentication. The physicians are also assisted with signing into medical records and completing any electronic signatures that are needed. This process will continue as long as needed to change behavior. SVW CEO discussed with each physician all clinical entries are to be signed, dated, and timed including H & P's and discharge summaries. Physicians who had delinquent charts were given admin. time to work with Health Information and get delinquent medical records. Health Information Manager states the physicians have been working with her and they have improved their delinquent rate significantly. 6/11/2013 is a scheduled Medical Staff Meeting. In January of 2013	06/11/2013	

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	<p>...Should the medical record(s) remain incomplete on the 30th day after patient discharge, a written notice shall be sent to the physician by the Chief of Staff, notifying him/her that his/her admitting privileges or consulting privileges, as appropriate, will be suspended."</p> <p>2. The medical record for patient #N1, who was admitted on 02/26/13 and expired on 03/03/13, indicated a history and physical (H&P) dictated 02/27/13, but not signed until 04/05/13, a discharge summary dictated 03/08/13, but not signed until 04/26/13, and telephone orders from 02/26/13 and 02/27/13 that were signed, but not dated or timed.</p> <p>3. The medical record for patient #N2, who was admitted on 01/07/13 and expired on 01/13/13, indicated a telephone order from 01/11/13 that was not signed until 02/19/13.</p> <p>4. The medical record for patient #N3, who was admitted on 10/31/12 and discharged on 11/02/12, indicated an H&P dictated 11/01/12, but not signed until 12/07/12, a discharge summary dictated 11/25/12, but not signed until 12/14/12, and telephone orders from 10/31/12 that were signed, but not dated or timed and another telephone order from 11/02/12 that was electronically</p>		<p>Health Information received direction from St. Vincent Health to revise the delinquent medical record. The policy was updated. The Medical Staff Rules and Regs have not been revised to match the policy. At the Medical Staff Meeting a review of the Delinquent Medical Record policy was completed with a motion to update the Rules and Regs to refer to the Health Information policy on Delinquent Medical Records. Health Information Manager and Credentialing Officer facilitated the discussion.6/11/2013 When a patient is discharged the chart is removed from the hard back cover and taken to Health Information department for coding and scanning. A suggestion was entered at Medical Staff meeting to placed the medical record in the physicians dictating area after discharge for 24 hours before taking it to Health Information allowing the physician time to dicatate the discharge summary and sign, date and time any enteries or dictations. The suggestion was passed and all associates involved in the process were informed of the change effective immediately. Health Information manager will report to the Medical Staff at next meeting if this process revision has decreased the delinquency rate.SVW Health Information Manager is responsible for ensuring entries in the medical</p>				

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	<p>signed by the physician on 12/07/12.</p> <p>5. The medical record for patient #N4, who was admitted on 01/27/13 and discharged on 01/30/13, indicated an H&P dictated 01/28/13, but not signed until 03/03/13, telephone orders from 01/27/13 and 01/30/13 that were electronically signed by the physician on 03/03/13, and another telephone order from 01/28/13 that was signed, but not dated or timed.</p> <p>6. The medical record for patient #N7, who was admitted on 12/14/12 and discharged on 12/17/12, indicated a discharge summary dictated 01/04/13 and signed 01/23/13.</p> <p>7. The medical record for patient #N8, who was admitted on 04/10/13 and discharged on 04/18/13, indicated a telephone order from 04/18/13 that was signed, but not dated or timed.</p> <p>8. The medical record for patient #N9, who was admitted on 01/20/13 and discharged on 01/24/13, indicated an H&P dictated 01/21/13, but not signed and telephone orders from 01/21/13 and 01/22/13 that were not signed, dated, or timed by the physician.</p> <p>9. The medical record for patient #N10,</p>		record are authenticated and dated according to our policies.				

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	<p>who was admitted on 03/06/13 and discharged on 03/12/13, indicated telephone orders from 03/06/13 and 03/07/13 that were signed, but not dated or timed.</p> <p>10. The medical record for patient #N11, who was admitted on 04/13/13 and discharged on 04/14/13, indicated an H&P dictated 04/14/13, but not signed and a telephone order from 04/13/13 that was not signed, dated, or timed by the physician.</p> <p>11. The medical record for patient #N13, who was admitted on 01/09/13 and discharged on 01/15/13, indicated a discharge summary dictated 03/18/13 and signed 03/29/13.</p> <p>12. The medical record for patient #N14, who was admitted on 03/27/13 and discharged on 04/04/13, indicated an H&P dictated 03/28/13, but not signed and telephone orders from 03/29/13 and 04/02/13 that were signed, but not dated, or timed by the physician.</p> <p>13. At 1:15 PM on 05/15/13, staff member A25 indicated he/she keeps a list of delinquent records for statistical purposes and reports to staff member A2, but both staff members indicated the steps in the Medical Staff Rules and Regs were</p>				

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	not followed regarding delinquency. 14. At 3:00 PM on 05/15/13, staff member A3 confirmed the medical record findings.			

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S000762	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(13)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(13) A discharge summary authenticated by the physician. A final progress note may be substituted for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instruction given to the patient and family.</p> <p>Based on review of the Medical Staff Rules and Regulations, medical record review, and interview, the facility failed to ensure all medical records for patients hospitalized for greater than 23 hours contained a discharge summary for 5 of 12 (#N2, N4, N8, N9, and N14) records reviewed.</p> <p>Findings included:</p> <p>1. The facility's "Medical Staff Rules and Regulations", adopted December 2012 and approved January 2013, indicated, "9.13 A discharge summary shall be written and/or dictated on the medical record of all patients hospitalized more than twenty-three (23) hours."</p>	S000762	<p>S 0762 All delinquent medical records are up to date. Physicians who had delinquent charts were given time away from their practice to work with Health Information and get delinquent medical records completed. Health Information Manager states the physicians have been working with her and they have improved their delinquent rate significantly. SVW CEO discussed with each physician the importance of keeping their medical records up to date and to notify her when time is needed. away from their practice to complete records. Health Information Manager is to keep the CEO updated. An informational inservice on Improving Documentation for Medical Staff is planned for July 2013. SVW Health Information</p>	06/11/2013			

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	<p>2. The medical record for patient #N2, admitted 01/07/13 and discharged 01/13/13, lacked a discharge summary or any discharge notation or documentation.</p> <p>3. The medical record for patient #N4, admitted 01/27/13 and discharged 01/30/13, lacked a discharge summary or any discharge notation or documentation.</p> <p>4. The medical record for patient #N8, admitted 04/10/13 and discharged 04/18/13, lacked a discharge summary or any discharge notation or documentation.</p> <p>5. The medical record for patient #N9, admitted 01/20/13 and discharged 01/24/13, lacked a discharge summary or any discharge notation or documentation.</p> <p>6. The medical record for patient #N14, admitted 03/27/13 and discharged 04/04/13, lacked a discharge summary or any discharge notation or documentation.</p> <p>7. At 3:00 PM on 05/15/13, staff member A3 confirmed the medical record findings.</p>		Manager is responsible for ensuring medical staff documentation follows the Medical Staff rules and regs.		

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, policy and procedure review, and interview, the facility failed to ensure a safe environment for patients by following facility policy regarding warmers in three patient care areas.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During the tour of the Med/Surg Unit at 12:30 PM on 05/14/13, accompanied by staff member A3, a warming cabinet containing blankets was observed in the linen room. A knob on the bottom of the unit was set on "8", but there was no way to determine what temperature that number designated. No thermometer was observed within or on the cabinet. 2. At 12:40 PM on 05/14/13, staff member A17 on the Med/Surg Unit indicated no temperature monitoring log 	S001118	S 1118 1-2. On 5/21/2013 a temperature monitor was installed by Plant Operations in the warming cabinet on the Medical/Surgical unit. A temperature monitoring log was placed on the warmer on 5/21/2013 to document daily temperature readings. If the temperature exceeds 130°F the nursing associates are to decrease the thermostat and the temperature is rechecked and recorded. "Just in time training" is being utilized by the Medical/Surgical Manager to educate staff. A review of the log sheet shows the temperature to be ranging 126 - 128 degrees. All Medical/Surgical associates will be provided education and a copy of the policy on Warming IV Fluids, Solutions, and Blankets on June 13, 2013 by the Medical / Surgical Manager. 4. 5/20/2013 The log sheet used to record the fluid and blanket warmer in	06/13/2013

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	<p>was kept.</p> <p>3. During the tour of the Recovery Room at 1:55 PM on 05/14/13, accompanied by staff member A2, a two-chamber Amsco Steris Warmer was observed with the top chamber registering 103 degrees Fahrenheit (F) and the bottom chamber registering 121 degrees F. One 1000 milliliter bag of Lactated Ringers intravenous fluid, dated 5/14/13, was in the top cabinet and blankets were in the bottom cabinet. A temperature monitoring log was on the unit.</p> <p>4. At 2:00 PM on 05/14/13, staff member A20, a nurse in the Recovery Room, indicated intravenous fluids were dated the morning they were put in the warmer and were usually used the same day; however, he/she did not know how long the fluids could remain in the warmer if they were not used that same day.</p> <p>5. During the tour of the Emergency Department at 9:20 AM on 05/15/13, accompanied by staff member A3, a Blickman Warming Cabinet, registering 140 degrees F and containing towels and blankets, was observed at the ambulance entrance.</p> <p>6. At 9:30 AM on 05/15/13, staff member A22, a nurse in the Emergency</p>		<p>recovery was revised and now includes the max. length of days (14) IV fluids can be stored in the warmer. A sign was also placed on the warmer door. Our usual practice is to place the IV fluid needed for the day in the warmer first thing in the morning. The date the IV is placed in the warmer is written on a sticker and place on the IV fluid bag. If a bag of IV fluid is not used, which is very rare it is used the next day. Surgery nurses have been informed to also write the expiration date on the sticker. A copy of the policy was given to the surgery nursing associates by the Surgery Manager. The Surgery Manager will randomly check the warmer to ensure the IV fluids have the date placed in warmer and expiration date on sticker. 5-6. Our CNO placed a log sheet on the blanket warmer in the Emergency Department to record daily temperature readings. Plant Operations programed the warmer unit to sustain a temperature of 130¿ F. A review of the log shows the temperature has been consistently 130¿F with one (1) reading of 129¿F. On 5/23/2013 Emergency Department associates were informed at a department meeting they need to record the temperature of the blanket warmer daily and the temperature is not to exceed 130¿F. If the temperature is</p>		

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	<p>Department, indicated they did not keep a monitoring log for the warmer.</p> <p>7. The facility policy "Warming of IV Fluids, Irrigation, and Blankets", last revised 01/2013, indicated, "A. IV fluids within their plastic overwrap and bottles of irrigation solution may be placed in a fluid warmer to a maximum of 104 degrees F (40 degrees C). 1. Fluids may be stored in the warmer for a maximum of 14 days. ...7. The IV bag or bottle of irrigation fluid must be labeled with the following information: a. Date placed in warmer. b. Expiration date. ...B. Warmed blankets provide comfort for chilled patients by interrupting heat loss to the environment. Acceptable temperature range for blankets is 114-122 degrees F. ...C. A temperature log will be maintained. The temperature must be recorded once each calendar day when the department is open."</p>		<p>above 130$\frac{1}{2}$ F they are to contact Plant Operations to re-program the unit and then recheck and document the temperature. Emergency Department charge nurse is responsible for recording the daily temperature. SVW Safety Officer is responsible for ensuring the hospital warmers are operated according to policy and procedure.</p>		

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S001162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on observation and document, the facility failed to comply with manufacturer's hot temperature recommendations for the Physical Therapy's Hydrocollator.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 1:30 PM on 5/15/2013, the Physical Therapy's Department was toured. The department had a Hydrocollator within the department. The Operation Manual instructions for the use and 	S001162	S 1162 On 5/15/2013 the Physical Therapy Manager obtained a copy of the Hydrocollator SS-2 operations manual. The recommended operating temperature is 160¿ - 165¿ F. The temperature was adjusted to 160¿ F by Plant Operations. All physical therapy associates were informed about the temperature setting and the sensitive thermostats. The associates are to record the temperature each day the department is open and call Plant Operations to adjust the thermostat setting if it exceeds 165¿F. All temperatures and any thermostat adjustments are to be documented on the Physical Therapy log sheet. A reveiw of the log sheet shows the temperature to be below 165¿F The Physical Therapy Manager	05/16/2013			

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	<p>operation of the St. Vincent Williamsport Hospital Hospital Physical Therapy's Hydrocollator SS-2 Master Heating Unit note the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 165 degrees Fahrenheit.</p> <p>3. The Physical Therapy Department May log for the hot packs revealed the first 11 open-days (May 1-3, 6-10, 13-15) of the department, the water temperature ranged between 172 and 176 degrees Fahrenheit. The temperatures exceeded the manufacturer requirement of 165 degrees Fahrenheit.</p>		will check the log sheet to ensure temperatures are taken and recorded.		