

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2015
NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WASHINGTON AVE EVANSVILLE, IN 47750		
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S 0000 Bldg. 00	<p>This visit was for a State licensure hospital survey.</p> <p>Dates of survey: 8/10/15 to 8/13/15</p> <p>Facility number: 005089</p> <p>QA: cjl 09/09/15</p> <p>IDR Committee met on 10-19-15: Tag S1226 deleted. JL</p>	S 0000	<p>Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. <u>Credible Allegation of Compliance:</u> For the purpose of any allegation that St. Mary's Medical Center (St. Mary's) is not in substantial compliance with Indiana Administrative Code IAC 15-1 and accompanying regulations, this response constitutes St. Mary's allegations of compliance. <u>Credible Allegation of Correction:</u> Even though St. Mary's disputes the allegations and the Indiana State Board of Health's claim that St. Mary's is in violation of Indiana Administrative Code IAC 15-1 and accompanying regulations, St. Mary's submits the following as the credible allegation of correction. For each of the following findings, St. Mary's incorporates by reference its response as set forth above.</p>		
S 0308	410 IAC 15-1.4-1 GOVERNING BOARD				

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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Bldg. 00	<p>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 provide evidence of department/job specific orientation for 2 of 4 director files reviewed (staff members #AA3 and AA7).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff member #AA3 (Director of Facilities) was hired 10/1/12. His/her personnel file lacked department/job specific orientation. Staff member #AA7 (Director of Health Information) was hired 10/8/07. His/her personnel file lacked department/job specific orientation. Staff member #A19 (Human Resources Manager) verified the above at 12:50 p.m. on 8/13/15. 	S 0308	<p>The department orientations of the Director of Facilities and the Director of Health Information were completed on 9/23/2015. Human Resources sent the Department/Job Specific orientation form has been sent to all St. Mary's Leadership to remind them it must be completed and in each new employee file, including contracted and agency personnel. Human Resources has also communicated to leadership that it has been added it under "documents for leaders" on St. Mary's Intranet via email on 9/23/15. The leadership staff has been asked to ensure all orientation requirement forms are in the folders of these personnel upon completion of the orientation period of each new staff member.</p>	09/23/2015

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S 0312 Bldg. 00	<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, 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 facility failed to complete annual performance evaluations for 2 of 2 agency nurses (staff members #N1 and N2).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff member #N1 (agency Registered Nurse) began employment at the facility on 8/16/13. His/her personnel file lacked evidence of a performance evaluation. Staff member #N2 (agency Registered Nurse) began employment at the facility on 11/5/13. His/her personnel file contained an evaluation from the staffing 	S 0312	<p>On September 9, 2015, this was discussed in Clinical Services with the Clinical Directors and Executive Directors as a finding by ISDH. An email was sent to all of leadership on 9/23/2015 to inform the directors of each clinical department that they must provide performance evaluation input to the staffing agency from which they receive their staff, on an annual basis, at a minimum. If the agency staff is here for greater than a year, the department director will be required to give the agency staff person an annual evaluation on their performance. If the agency staff is here for a shorter time period, a performance evaluation should be provided to the agency</p>	09/23/2015

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S 0406 Bldg. 00	<p>agency dated 7/6/15, however lacked any input from the facility.</p> <p>3. Staff member #A19 (Human Resources Manager) verified the above in interview beginning at 12:15 p.m. on 8/13/15 and indicated that the facility had no input on the performance evaluation for staff member #N2.</p> <p>4. Staff member #A1 (Accreditation Manager) indicated in interview at 1:50 p.m. on 8/13/15 that the facility has no policy for evaluations but the practice is to do them annually.</p> <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. Based on document review and interview, the hospital failed to ensure 4 off-site areas of the hospital participated</p>	S 0406	<p>at time of departure. The director must copy the performance evaluation to HumanResources@stmarys.org. It has been added to the Human Resources files on Contingent Workers. The Nursing Directors and Human Resources will be accountable to ensure these performance evaluations are completed.</p> <p>St. Mary's Executive Director of Quality Management and Reporting held a meeting with the Vice-President of Medical Affairs,</p>	09/25/2015			

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	<p>in the quality assessment and performance improvement (QAPI) program (Surgicare Crosspoint, Center for Advanced Medicine, Westside Radiology and Northbrook) and failed to ensure 11 directly provided services were included in evaluation (Electromyography (EMG), Lithotripsy, Infusion therapy, In-patient Magnetic Resonance Imaging (MRI), Neurosurgical services, Positron Emission Tomography (PET) scans, Peripherally Inserted Central Catheter (PICC) services, Psychology, Diagnostic Radiology, Reconstructive Surgery and Renal Dialysis) and 2 contracted services (Biohazardous Waste Hauler and Blood Bank).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the document titled Performance Improvement and Patient Safety Plan Fiscal Year 2015, indicated in Appendix A: The purpose...is to provide: 1. an oversight council for direction and guidance for quality and patient safety initiatives across the hospital. The plan was approved 8/29/14. 2. Review QAPI meeting minutes and reports from fiscal year (FY) 2015 lacked evidence of quality reporting from the 		<p>Vice-President of Corporate Compliance, Risk and Accreditation, Vice-President of Cardiovascular and Systems Support Services, Vice President of Clinical Support and Ancillary Services, and Accreditation Manager on 9/1/2015. She presented a list of services/modalities to discuss adding to our QAPI program per suggestions of the ISDH surveyor. An email was sent on 9/11/15 to each of the leaders of these sites, departments and/or services requesting QAPI be collected and presented, including benchmarks, on the services presented by the ISDH surveyor. The contact information of our Executive Director of Quality and Accreditation Manager was provided for guidance. Report on these QAPI activities will begin October 1, 2015. They will be required to submit data per schedule assigned report-out dates as determined by the Ambulatory and Ancillary Committee and the Quality Patient Safety Council. The newly created Medical Staff Quality Committee will receive the reports related to medical staff services (reconstructive surgery, neurosurgical services) performance and then provide the report on these services to the Governing Board on an annual basis. Surgicare at Crosspointe, Center for Advanced Medicine, Westside Radiology and</p>				

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	<p>following off-sites: Surgicare Crosspoint, Center for Advanced Medicine, Westside Radiology and Northbrook. The documents also lacked evidence of QAPI evaluation/review of the following services: Electromyography (EMG), Lithotripsy, Infusion therapy, In-patient Magnetic Resonance Imaging (MRI), Neurosurgical services, Positron Emission Tomography (PET) scans, Peripherally Inserted Central Catheter (PICC) services, Psychology, Diagnostic Radiology, Reconstructive Surgery and Renal Dialysis.</p> <p>3. On 8/12/15 at 11:45am, A8, Executive Director of Quality, indicated the 4 off-sites: Surgicare Crosspoint, Center for Advanced Medicine, Westside Radiology and Northbrook, had not reported quality activity to the QAPI committee/program. A8 also indicated the 11 directly provided services (Electromyography (EMG), Lithotripsy, Infusion therapy, In-patient Magnetic Resonance Imaging (MRI), Neurosurgical services, Positron Emission Tomography (PET) scans, Peripherally Inserted Central Catheter (PICC) services, Psychology, Diagnostic Radiology, Reconstructive Surgery and Renal Dialysis) and the 2 contracted services (Biohazardous Waste Hauler and</p>		<p>Northbrook, Electromyography (EMG), Lithotripsy, Infusion therapy, In-patient Magnetic Resonance Imaging (MRI), Neurosurgical services, Positron Emission Tomography (PET) scans, Peripherally Inserted Central Catheter (PICC) services, Psychology, Diagnostic Radiology, Reconstructive Surgery, Renal Dialysis, Bio-hazardous Waste and Blood Bank will begin reporting on the following QAPI activities beginning October 1, 2015. They will submit data per schedule assigned report-out dates as determined by the Ambulatory and Ancillary Committee and the Quality Patient Safety Council. Their reports will include benchmarked goals. Action plans will be discussed and determined, as necessary. All reports to the Quality Patient Safety Committee and the Ambulatory and Ancillary Performance Improvement Committee are reported up to the Governing Board.</p>		

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S 0554 Bldg. 00	<p>Blood Bank) had not been included in QAPI reviews for FY 2015.</p> <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 document review, observation and interview, the facility failed to follow its policies regarding infection control and housekeeping in seven (7) areas toured.</p> <p>Findings:</p> <ol style="list-style-type: none"> Facility policy 1594380, Environmental Services, indicated all patient care and non-patient care areas shall be cleaned and/or disinfected, keeping in mind Standard Precautions and infection control procedures. This includes: D. Wipe tables, furniture, counters, cabinets and others. M. Dust mop floor. On 8/10/2015 at 1230 hours, while on tour of the Center for Advanced 	S 0554	<p>Center for Advanced Medicine: the soiled utility room had trash and dust on the floor.</p> <p>Environmental Service has been informed of the finding on 9.11.2015. The staff was informed of the trash on the floor on the day of the finding, 8/10/2015. They were informed by The Manager of Radiology that the expectancy is for staff to pick up trash as needed and not to deposit trash on the floor. If a staff member is seen to be non-compliant, their supervisor will provide disciplinary action per our Human Resource policy, Personal Conduct/Corrective Action. The Director of Environmental Services will round and observe the soiled utility room and other soiled utility rooms to ensure they are being cleaned per required standards. Any trash issues noted will be</p>	09/18/2015

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	<p>Medicine, accompanied by staff member A9, Manager, Imaging Services, the following was noted:</p> <ul style="list-style-type: none"> a. The soiled utility room had trash and dust on the floor. b. The crash cart had a dusty layer on top of it. c. The Computerized Tomography room had not been cleaned since the week of 8/2-8/8/2015, according to the cleaning log. The floor had trash on it and was soiled and dusty. The sink counter in the room had a sticky substance on it. <p>3. Staff member A9 concurred with these findings.</p> <p>4. On 8/10/2015 at 1445 hours, while on tour of the Obstetrics unit, accompanied by staff member A2, Risk Manager, the following was noted:</p> <ul style="list-style-type: none"> a. Trash and dust on the floor of the linen storage room. b. The top of the crash cart had a layer of dust on it. <p>5. Staff member A2 concurred with these findings.</p> <p>6. A. Hospital Policy 1448128 indicated G. Hand hygiene must be performed: 1. Before any patient care is given. 4. Before putting on gloves and</p>		<p>corrected immediately and then reported to the Manager of Imaging Services, as applicable.</p> <p>Center for Advanced Medicine: The crash cart had a dusty layer on top of it. The crash carts are cleaned with a Cavicide wipe after each use in a Code. If the patient is suspected of having Clostridium Difficile, the Bleach Wipes will be used. The Respiratory Therapists are responsible for checking the crash cart daily. They have been informed by their supervisor, the Director of Respiratory Services, to include the responsibility for keeping the cart dust-free. There is a column on the daily check sheet to log when cleaned/dusted. A weekly audit of 10 crash carts will be completed for a minimum of 8 weeks, or until compliant, by Accreditation to ensure these are being kept dust-free. The results will be sent to the Director of Respiratory Services to follow-up on issues. Once compliance has been met, weekly spot-checks will occur with environmental rounds. These spot checks will extend to monthly, if compliance is met. Non-compliance issues will be reported to Director of Respiratory Services.</p> <p>Computerized Tomography room: had not been cleaned since the week of 8/2-8/8/2015, according to the cleaning log. The floor had trash on it and was soiled and dusty. The sink</p>				

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	<p>after removal of gloves. 7. Before and after any invasive procedures such as administering injections.</p> <p>7. On 8/11/2015 at 0900 hours, while on tour of offsite surgery center at Crosspoint, accompanied by staff member A1, Accreditation Manager, it was noted that nursing staff C1 in Bay 5 did not do hand hygiene before and after patient N26 contact, while getting patient ready for a surgical procedure. The same RN was noted to drop an ink pen on floor while wearing gloves, picked it up and then started patient IV (intravenous) line, without hand hygiene or changing gloves. Staff member A1 concurred with these findings.</p> <p>8. On 8/11/15 at 0930, while on tour of the Emergency Department, accompanied by staff member C2, ED Manager, the following was observed:</p> <ol style="list-style-type: none"> The tops of the adult and pediatric crash carts had a layer of dust on them. The patient refrigerator had brownish spilled substance on two shelves in it. The patient microwave oven had brownish substances on the interior walls and glass turntable. <p>9. Staff member C2 concurred with these findings.</p>		<p>counter in the room had a sticky substance on it. It is an expectation that each patient exam room within the Imaging Services Department be cleaned on a daily basis excluding any days when equipment/room is not in service. Imaging staff are responsible for cleaning all work surfaces, equipment, and accessories such as IV poles, sponges, etc. Environmental Services is responsible for cleaning floors and trash disposal in patient care areas. Reinforcement of this expectation was clearly communicated to all Imaging staff by the Lead/Chief Techs of each Imaging modality on the day of the survey, 8/10/2015, and each day following until all staff had received the information. Documentation of daily cleaning on the Imaging Services Room Cleaning log is now required of staff member completing this cleaning. When room is closed (weekend/holiday/service), this is documented on the log. To assure that rooms are being cleaned as expected, it is of the Lead/Chief Tech of each modality to review cleaning logs and cleanliness of rooms and initial on a weekly basis. If cleaning has not been completed, as expected, the Lead/Chief Tech will complete appropriate follow up with staff. This process will be put into place on August 17, 2015. The Obstetrics unit: Trash</p>				

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	<p>10. On 8/12/2015 at 1130 hours, while touring the inpatient therapy department, hydrotherapy room, accompanied by staff member A2, Risk Manager, it was noted that the plastic covering the patient table and pillow both had tears in the plastic covering, making adequate cleaning of the surfaces between patients impossible.</p> <p>11. Staff member A2 concurred with these findings.</p> <p>12. Policy 1594380, Environmental Services, General Room Cleaning indicated that restrooms should be cleaned completely per restroom cleaning policy, as part of patient room cleaning.</p> <p>13. On 8/12/2015 at 1300, while on tour of the eight patient rooms of the Sleep Center, accompanied by staff member A2, it was noted that cleaned patient room #2's bathroom smelled foul and the toilet had yellowish liquid on the back of it. The toilet interior also appeared soiled with brownish substance.</p> <p>14. Staff member A2 concurred with these findings.</p> <p>15. Sleep Center policy 1434871 indicated B. Positive Airway Pressure Equipment 2. Humidifier: after each use, wash in hot (140-160 degree), soapy</p>		<p>and dust on the floor of the linen storage room. Environmental Service has been informed of the finding on 9.11.2015. The staff was informed of the trash on the floor on the day of the finding, 8/10/2015 by the Director of Labor and Delivery. They were informed that the expectancy is for staff to pick up trash as needed and not to deposit trash on the floor. If a staff member is seen to be non-compliant, their supervisor will provide disciplinary action per our Human Resource policy, Personal Conduct/Corrective Action. The Director of Environmental Services will round and observe the soiled utility room and other soiled utility rooms to ensure they are being cleaned per required standards. Any trash issues noted will be corrected immediately and then reported to the Manager of Imaging Services, as applicable. The Obstetrics unit: top of the crash cart had a layer of dust on it. The crash carts are cleaned with a Cavicide wipe after each use in a Code. If the patient is suspected of having Clostridium Difficile, the Bleach Wipes will be used. The Respiratory Therapists are responsible for checking the crash cart daily. They have been informed by their supervisor, the Director of Respiratory Services, to include the responsibility for keeping the cart dust-free. There is a column on the daily check</p>				

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	<p>water. Rinse well. Place humidifier chambers in Control III soak bucket for 10 minutes to disinfect. Rinse well. After soak is completed, rinse thoroughly with hot tap water and place on shelf in the sterile dryer to dry.</p> <p>16. Patient rooms #2, 3, 6 and 7, which were cleaned after patient use had oxygen humidifiers which still contained fluid from the previous patient, and appeared not to have been cleaned and dried, per cleaning policy, risking cross contamination from one patient to another by the inhalation of dirty water.</p> <p>17. Staff member A2 concurred with these findings.</p> <p>18. Review of the P&P titled Infection Control indicated in G. Patient Care Equipment and Supplies, 1. Clean and contaminated supplies/equipment are stored separately. The P&P was approved 12/9/13.</p> <p>19. On 8/12/15 during facility tour between 2:00pm and 4:00pm, in the presence of S6, Executive Director of Ambulatory Operations, and S7, Manager of Imaging, in a clean supply/equipment storage room of the radiology department the following was observed: shelves with sterile packaged patient supplies and a cart with a microscope on top.</p>		<p>sheet to log when cleaned/dusted. A weekly audit of 10 crash carts will be completed for a minimum of 8 weeks, or until compliant, by Accreditation to ensure these are being kept dust-free. The results will be sent to the Director of Respiratory Services to follow-up on issues. Once compliance has been met, monthly spot-checks will occur with environmental rounds. Non-compliance issues will be reported to Director of Respiratory Services. Surgicare at Crosspointe: it was noted that nursing staff did not do hand hygiene before and after patient contact while getting patient ready for a surgical procedure. The St. Mary's policy on Hand Hygiene (Hand Washing and Hand Sanitizing), which follows the CDC guidelines, was given to the associate as well as addressed at our September's staff meeting on 9/21/15. During the staff meeting, policy# 1448128 was read aloud to associates that indicates that Hand Hygiene must be performed: Hand Hygiene must be performed: 1. Before any patient care is given. 2. Before and after contact with health care environment. 3. Between patients in the health care worker's care. 4. Before putting on gloves and after removal of gloves. 5. Between different procedures on the same patient (e.g., emptying bedpan then</p>	

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	<p>20. On 8/12/15 at 2:30pm, S7 indicated the microscope on the "cytology" cart was used in that room for tissue observation of computed tomography (CT) samples brought in from the adjacent procedure room.</p> <p>21. A6 and A7 indicated the process did allow for contaminated material to be brought in with clean supplies.</p>		<p>drawing blood from a central line). 6. Before and after preparing medications. 7. Before and after any invasive procedure such as administering injections. 8. After sneezing, coughing, blowing nose or combing hair. 9. After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood and body fluids, secretions, or excretions; 10. After touching inanimate objects that are likely to be contaminated with virulent or epidemiologically important microorganisms; these sources include urine-measuring devices or secretion collection containers. 11. After taking care of an infected patient or one who is likely to be colonized with microorganisms of special clinical or epidemiologic significance, for example multi-resistant bacteria. 12. Before and after contact with wounds, whether surgical, traumatic, or associated with an invasive device (e.g. an intravenous cannula entrance wound). 13. After leaving an isolation area or after handling articles from an isolation area. 14. After touching blood or other body substances (or patient care equipment contaminated with these), broken skin or mucous membranes—even if you wear gloves. 15. After completion of duty. Hand Hygiene observations will continue to be monitored for adherence. We will increase our</p>	

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			<p>hand hygiene observations to 50/month to report to St. Mary's Infection Control Committee to which are included with the outpatient department hand hygiene reports. The Emergency Department,; dust on top of crash cart. The crash carts are cleaned with a Cavicide wipe after use in each Code. If the patient is suspected of having Clostridium Difficile, the Bleach Wipes will be used. Respiratory Therapy will keep the inpatient departments, for which they are responsible to check daily, dust-free. The Operating Room and the Emergency Departments will assign a staff member to keep the cart dust free. There is a column on the daily check sheet to log when cleaned/dusted. RT maintains the cart in the CLOR and checks it daily. The Emergency Department: the patient refrigerator had brownish spilled substance on two shelves in it. Food Services is responsible for keeping the inside of the refrigerators clean. If there are any spills or splatter, the staff member responsible for it will clean it at that time with mild soap (dish detergent) and warm water. Environmental Services is responsible to clean the outside of the refrigerator. The Emergency Room staff was informed/reminded of the responsibilities of cleaning up their own splatters and messes in their September staff meeting.</p>		

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			<p>The Food Services manager over the staff responsible for the department refrigerators reminded her Food Services staff of these responsibilities in their September meetings. These will be included on the department environmental tours (Safety and Accreditation), performed, at a minimum of twice a year. Feedback on issues will be sent to the manager over the responsible staff and copied to the Food Services Director. The Charge Nurses in the Emergency Room will spot check and follow-up with issues with the staff and Food Services, as needed. These actions were completed by September 18, 2015. c. The Emergency Department: the patient microwave oven had brownish substances on the interior walls and glass turntable. The microwaves are to be cleaned monthly with mild soap (dish detergent) and warm water. A log demonstrating the cleaning will be kept. Between the monthly cleaning, they should be cleaned after spills and splatters. The staff person using the microwave is responsible for cleaning their own splatters and spills after each use. Environmental Services is responsible to clean the outside of the microwave. The Emergency Room staff was informed/reminded of the responsibilities of cleaning up their own splatters and messes in</p>	

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			<p>their September staff meeting. These will be included on the department environmental tours (Safety and Accreditation), performed, at a minimum of twice a year. Feedback on issues will be sent to the Director over the Emergency Department staff. The Charge Nurses in the Emergency Room will spot check and follow-up with issues with the staff, as needed. These actions were completed by September 18, 2015. The inpatient therapy department, hydrotherapy room: the plastic covering the patient table and pillow both had tears in the plastic covering. The physical medicine staff was educated at the department staff meeting(s) on 9/15/15 and 9/18/15 They were instructed that if they notice a tear like this in the future, they should immediately take the pillow out of service due to infection risks. When our pillow supply becomes low, they are to notify the supervisor to ensure a pillow order is placed for the comfort of our patients. A work order was placed to remove the tan/brown hi-lo table from a patient care area on 9/14/15 and on 9/15/15 the tan/brown hi-lo table was removed from the patient care area and replaced with another hi-lo table without any tears in it. A second work order to replace the other table (hospital cart with a blue mat) was put into the system on 9/15/15. In the department staff</p>	

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			<p>meeting(s) on 9/15/15 and 9/18/15, the staff were instructed to take all mats with tears out of service, due to infection risks. Inform the supervisor so that he/she can either have the table replaced or a work order put in to have the tear repaired. The Sleep Center: the cleaned patient room #2's bathroom smelled foul and the toilet had yellowish liquid on the back of it. The toilet interior also appeared soiled with brownish substance. On 8/12/15, on the day of the finding, a ticket was put in to Medxcel to check bathroom smell. An hour later the toilet was checked and found to have a broken part, causing a leak. The part ordered immediately. On 8/13/15, the toilet was repaired by maintenance. The bathroom was cleaned thoroughly by Environmental Services. For the next several days, the bathroom wash checked to ensure there was no leak or odor. The Sleep Center: Patient rooms #2, 3, 6 and 7, which were cleaned after patient use had oxygen humidifiers which still contained fluid from the previous patient, and appeared not to have been cleaned and dried. On 8/12 /15, the humidifier chambers in patient rooms #2, 3, 6, and 7 were removed by staff and cleaned per policy. On 8/13/15, an email sent to all staff of findings along with cleaning policy. A cleaning log has been</p>	

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			<p>developed and assigned, to be completed (day shift staff person), which will demonstrate that they are cleaned.. It must be done per policy (EQ-01 Cleaning and Maintenance of Equipment and Sensors): After each use: Wash in hot [140-160 degree] soapy water. Rinse well. Place humidifier chambers in Control III soak bucket for 10 minutes to disinfect. Rinse well. After soak is complete, rinse thoroughly with hot tap water and place on shelf in the sterile dryer to dry. There will be checks twice a week on the humidifiers and the log for 8 weeks to ensure compliance is being met. Once compliance is ensured, monthly spot checks will occur on an ongoing basis. Staff verified understanding of cleaning policy at staff meeting on 9/15/15. Radiology: in a clean supply/equipment storage room of the radiology department the following was observed: shelves with sterile packaged patient supplies and a cart with a microscope on top. allowing for contaminated material to be brought in with clean supplies. The Cytology cart with microscope was moved from the clean supply storage room immediately after the ISDH surveyor's tour on 8/12/2015, of the Inpatient Imaging Services Department. The Cytology cart is now kept at the back of the CT procedure room. All CT staff,</p>	

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S 0804 Bldg. 00	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(1) Conduct outcome oriented performance evaluations of its members at least biennially. Based on document review and interview, the medical staff (MS) failed to conduct outcome oriented performance</p>	S 0804	<p>cytology techs, and Radiologists have been made aware of this change. The cleaning procedure has been reinforced of wiping the microscope down with a Cavacide wipe after each patient use and place a clean cover over the microscope. Should the Cytology cart/microscope be needed in another area of Imaging where biopsies are performed such as Ultrasound or Interventional Radiology, the cart will be wheeled to that area for use, cleaned as described, and returned to the CT procedure room for storage. This will be checked by the Lab Director and the Radiology Director for compliance.</p> <p>Primary Source, in collaboration with the Vice-President of Medical Affairs developed a form for the</p>	10/30/2015	

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S 0912 Bldg. 00	<p>evaluations for 4 of 4 reappointed allied health (AH) MS members (AH#2, AH#3, AH#4 and AH#5) at least biennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of 4 reappointed AH MS (AH#2, AH#3, AH#4 and AH#5) credential files lacked evidence of performance evaluations. 2. On 8/11/15 at 10:15am, A11, Primary Source Coordinator, indicated performance evaluations were not kept in the credential files and would need to be obtained from A7, Vice President (VP) of Medical Affairs, or A8, Executive Director of Quality. 3. On 8/13/15 at 12:15pm, A8 indicated he/she did not pull the data for performance evaluations of AH MS members. 4. On 8/13/15 at 12:30pm, A7 indicated performance evaluations were not documented for AH MS members. 				<p>required performance evaluations of Allied Healthcare to be utilized by the Medical Staff members.</p> <p>On 9/24/2015, the Vice-President of Medical Affairs prepared a cover letter that is being sent to the sponsoring collaborative physician on all of the employed and non-employed Allied Health Providers. The sponsoring collaborative physician is to complete the performance evaluation within 30 days and return to Primary Source. The letter contains an explanation of the requirements and expectations.</p> <p>For future use, we will include it in our 2 year annual review process for all employed and non-employed Allied Health Providers. On the off years, we will send this to all employed and non- employed providers as a stand-alone Professional Evaluation Form.</p> <p>Primary Source and the Vice-President of Medical Affairs will collaborate to ensure these are returned as requested.</p>		
	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)						

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	<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 document review and interview, the nurse executive failed to ensure physician orders were followed for 4 of 6 open patient records reviewed (patients #11, 12, 13 and 26).</p> <p>Findings include:</p> <p>1. Review of patient #11 medical record</p>	S 0912	<p>6 East: An order was written at 1904 hours on 8/6/15 to weigh the patient daily at 0600 hours. The record lacked evidence that the patient was weighed on 8/10/15 or 8/11/15 per order. A Teach 5 notice form was given to each RN and PCT on 9-25-15. They were given to the staff that worked on 8-10-15 and 8-11-15,</p>	09/25/2015

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	<p>indicated the following:</p> <p>(A) He/she was admitted to the 6 East Oncology Unit on 8/6/15.</p> <p>(B) An order was written at 1904 hours on 8/6/15 to weigh the patient daily at 0600 hours.</p> <p>(C) The record lacked evidence that the patient was weighed on 8/10/15 or 8/11/15 per order.</p> <p>2. Staff member #18 (RN, registered nurse) verified the above at 11:00 a.m. on 8/11/15.</p> <p>3. Review of patient #12 medical record indicated the following:</p> <p>(A) He/she was admitted to the 5 South Medical/Surgical unit on 8/4/15.</p> <p>(B) An order was written on 8/9/15 at 12:04 p.m. for midline incision dressing change with Nugauze three times a day.</p> <p>(C) The record lacked evidence that the dressing was changed at all on 8/10/15.</p> <p>4. Staff member #17 (RN) verified the above in interview at 11:30 a.m. on 8/11/15 and indicated that he/she did not use the Nugauze on the dressing change that he/she had completed on 8/11/15.</p> <p>5. Review of patient #13 medical record indicated the following:</p> <p>(A) The patient was admitted to the Medical Intensive Care Unit on 8/9/15.</p>		<p>the days the weights were missing. This requires each of them to teach 5 others the importance of obtaining daily weights, as ordered. The staff who received the Teach 5 notices are required to return them to the Director of 6 East for confirmation of completion. They were given to the following: Five Registered Nurses, two Patient Care Techs, and one Student Nurse Clinical Supervisors reminded staff about the importance of daily weights during daily safety huddles, beginning 9/24/2015. An e-mail was sent to 6 East staff on 9-25-15 reminding of the importance of following orders and daily weights. This information will be shared again at the October unit staff meeting.</p> <p>5 South Medical/Surgical: an order was written for midline incision dressing change with Nugauze three times a day. The record lacked evidence that the dressing was changed at all on 8/10/15. In the search for the root cause, it was discovered that the physician verbally informed the nurse, while in the patient's room, that he was going to change the type of dressing and frequency. However, the MD did not revise his order. The RN did not notice that he did not change the order. Upon the finding by the surveyor on 8/11/2015, the MD was called after the chart was reviewed and the order was clarified and entered. The Director of 5 South</p>		

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	<p>(B) An order was written on 8/9/15 at 0637 hours to report a heart rate above 120 or systolic blood pressure of less than 90. The patient's heart rate was 125 at 1330 hours on 8/10/15, 122 at 1430 hours on 8/10/15, and 123 at 1900 hours on 8/10/15. The patient's blood pressure was 88/44 at 0614 hours on 8/10/15, 82/36 at 1100 on 8/10/15, and 85/68 at 12:00 p.m. on 8/10/15.</p> <p>(C) The medical record lacked documentation that the physician was notified of the vitals per order.</p> <p>6. Staff member #22 (RN) verified the above at 12:00 p.m. on 8/11/15.</p> <p>7. Review of patient #26 medical record indicated the following: (A) An order was written at 8/5/15 at 0329 hours for vital signs three times a day. (B) The record indicated that vitals were taken only once on 8/6/15 and taken twice on 8/8/15.</p> <p>9. Staff member #40 (RN) verified the above at 11:00 a.m. on 8/12/15.</p>		<p>reviewed the missed order and lack of clarification with the RN and the rest of the staff in staff meeting 9/25/2015. The review included the importance of rounding with the physicians and verifying that they have entered the orders that the MD has verbally stated and has been repeated back to him for clarification. If the order has not been entered and you have actually heard the order stated, repeated and verified, then you may enter the order on behalf of the physician. If there is a question/concern about the order, it was not repeated and verified, or there is a discrepancy between what is written and what is being done, call MD for clarification.</p> <p>Medical Intensive Care Unit: an order was written to report a heart rate above 120 or systolic blood pressure of less than 90. medical record lacked documentation that the physician was notified of the vitals per order. The Director of ICU met with his staff on 8/22/2015. He presented the following information: if the patients clinical presentation causes them to question notifying the physician per the order, clarification needs to happen with the physician. Call the physician per order and have the order changed by the physician. To be mindful of both the RN and physician's time, review orders that contain parameters or "call"</p>		

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S 0952 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures.		orders with the physician when they are first written. Review to ensure the orders seem relevant to the plan of care. If not, then clarify with the ordering physician. Follow-up spot checks of physician orders with parameters or "call" orders will occur by the Director of ICU and his Clinical Supervisors. Medical ICU: an order was written for vital signs three times a day. The record indicated that vitals were taken only once on 8/6/15 and taken twice on 8/8/15. The Director of ICU met with his staff on 8/22/2015. He reviewed the finding and discussed the requirements for following the physician orders. They discussed that if the patients clinical presentation causes them to question notifying the physician per the order, clarification needs to happen with the physician. If the order does not seem relevant to the plan of care, then clarify with the ordering physician. Follow-up spot checks will occur by the Director of ICU and his Clinical Supervisors to ensure physicians orders are being followed.	

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	<p>If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6).</p> <p>Based on document review and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for seven of twenty patients.</p> <p>Finding include:</p> <p>1. The policy, "Blood and Blood Components Administration, Guidelines and Table", approved 7/08/14, read: "Physician and RN, 2 RNs or RN and LPN must document the following, prior to spiking the unit of blood, except in emergent cases. Physician's order for administration. (need Order for Type and Cross and Give). Transfuse start: document start date and time. repeat vital signs at 15 minutes</p>	S 0952	<p>Meeting with clinical directors and lab directors was held on Tuesday, September 22, 2015. The ISDH findings were reviewed. The Blood Transfusion policy was revised and the revisions were discussed and approved by the clinical directors and lab directors.</p> <p>A presentation of "how to correctly enter an order for a transfusion was presented by the Clinical Informaticist. The Clinical Informaticist will be working with the physicians on the units and in the physicians lounge to ensure they understand the correct method to enter a transfusion order. A MyLearning module is being revised that will include information on entering a transfusion order, vital sign time requirements, and all documentation requirements for transfusing blood. This module will be assigned to all clinical nurses in October, 2015. Accreditation will make the revisions and documentation requirements of the policy the Focus on Care for October 2015. It will be sent to all department directors on September 28, 2015.. A blood audit will be included with the Focus on Care Education. It will consist of</p>	10/19/2015

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	<p>from start time of transfusion. When blood or components infused: Repeat vital signs and complete transfusion form (time completed and unfavorable reaction, yes or no)."</p> <p>2. In review of seven patients receiving fourteen blood units, ten of these received-units did not have complete documentation, per policy, on the Blood Transfusion Record form:</p> <p>Patient #1 --Unit #3a administered on 8/05/15 at 12:30 a.m. and unit #3b administered on 8/05/15 at 1:20 a.m.: Both units were administered without benefit of an order.</p> <p>Patient #3 --Unit #3a administered on 8/08/15 at 12:50 a.m.: The 15 minute vitals were documented at 13 minutes --Unit #3b administered on 8/08/15 at 04:36 a.m.: There was</p>		<p>documentation requirement elements and a correct order for the bold transfusion. Each department that transfuses blood will be required to audit, at a minimum, 10 charts in October. If they do not transfuse 10 units of blood in the month of October, they are to all charts of patients that receive blood. The staff members with documentation omissions will be informed by their supervisor. As applicable (i.e. pattern of omissions that continues after discussion with director), their supervisor will provide disciplinary action per our Human Resource policy, Personal Conduct/Corrective Action.</p> <p>The clinical directors and lab directors included a review of our current electronic application blood transfusion data collection. We found that our system that was in place when the surveyor was here in August, 2015 was fairly inaccurate. We aborted the use of this system and are using a new system. The report is run for review daily. In the analysis of our current system application, lab has noted we are still missing some information we would like to include in the report. The Clinical Informaticist is taking this issue to the Sunrise Clinical Team in October, 2015 to include in the report. If these changes are acceptable, we can audit the charts for omissions much more efficiently.</p>				

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	<p>no documented 'end time' for this unit</p> <p>Patient #5 --Unit #3a administered on 8/07/15 at 2:40 p.m.: The 15 minute vitals were documented at 20 minutes; there was no documented 'end time' for this unit</p> <p>Patient #6 --Unit #3a administered on 8//15 at (not available): There was no 'start time' documented; the 15 minute vitals were not documented; there was no documented 'end time' for this unit</p> <p>Patient #7 --Unit #3a administered on 8/03/15 at 10:47 p.m.: The unit was documented to have started at 10:47 p.m. in lieu of the correct time of 8:47 p.m. --Unit #3b administered on 8/04/15 at 1:39 2:40 p.m.: There was no documented 'end time'</p>			

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S 1024 Bldg. 00	<p>for this unit</p> <p>Patient #14 --Unit #3b administered on 8/03/15 at 5:23 p.m.: There was no documented 'end time' for this unit</p> <p>Patient #20 --Unit #3b administered on 8/06/15 at 1:24 p.m.: There was no documented 'end time' for this unit</p> <p>3. On 8/11/15 at 2:00 p.m., staff member #A14 acknowledged that the above-listed patients had received blood without benefit of complete documentation, per policy, as required.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals</p>						

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	<p>are stored and which address, but are not limited to, the following:</p> <p>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on document review, observation, and staff interview, the facility failed to ensure medications were stored in a secure manner for 1 of 8 units and failed to ensure outdated/unusable medications were removed from patient stock and returned to pharmacy per policy for 4 of 8 units toured.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Medication Security" last reviewed/revised 8/20/14 states under policy statement: "All medications, prescription and non-prescription, stored in the pharmacy and throughout the hospital and off-campus locations will be stored in a secure manner." 2. Facility policy titled "Medication Storage Area Inspection (Occupational and Convenient Care)" last reviewed/revised 4/12/13 states on page 2 of 3: "9. Outdated or otherwise unusable drugs will be identified and returned to the Pharmacy for proper disposition." 	S 1024	<p>During tour of the Medical Intensive Care Unit beginning at 11:45 a.m. on 8/11/15, three (3) vials of Intravenous Protonix were observed unsecured on top of the Pyxis unit.Action Plan: September 15, 2015 Issue: Unsecured Medications in Medical ICU During the most recent ISDH survey we were found to have unsecured medications in the Medical ICU. This survey was conducted on 8/11/15 and there were 3 vials of Intravenous Protonix that were observed to be unsecure. The staff have been re-educated on the expectation that all medications, to include controlled and uncontrolled medications need to be secured in the patients medication drawer. All medications that are partially utilized need to be wasted per policy and/or returned to pharmacy via the tube system. The re-enforced education was solidified by having all of the staff review the Medication: Controlled Substances-Storage, Ordering, Dispensing, Discrepancies, Waste- Outside of the Pharmacy Department policy, and this was</p>	09/25/2015

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	<p>3. Facility policy titled "Medication Storage" last reviewed/ revised 9/29/14 states on page 2 of 3: "4. Nursing Units a. All patient specific medications kept on the nursing units are stored in locking medication carts or cabinets. b. All non-patient specific medications (floorstock items) are kept in Pyxis Medstations."</p> <p>4. During tour of the Medical Intensive Care Unit beginning at 11:45 a.m. on 8/11/15, three (3) vials of Intravenous Protonix were observed unsecured on top of the Pyxis unit.</p> <p>5. Staff member #N01 (Department Manager) indicated the Protonix was to be returned to pharmacy.</p> <p>6. During tour of the Rehab Unit beginning at 10:00 a.m. on 8/12/15, two (2) expired 1000 ml bags of Lactated Ringers with 5% Dextrose were observed in the storage room. Both expired on 5/1/15. Also there were 2 expired 1000 ml bags of Lactated Ringers with an expiration date of 8/1/15.</p> <p>7. During tour of the Surgery Department beginning at 11:55 a.m. on 8/12/15, 2 of 2 crash carts contained expired medications. Expired items</p>		<p>added to the associate accountability form which all staff signed. This was completed on 8/22/15. Follow up is completed during Leadership Rounding to ensure that medications are being properly secured. Direct follow up and coaching is conducted as needed. Rehab Unit: two (2) expired 1000 ml bags of Lactated Ringers with 5% Dextrose were observed in the storage room. Both expired on 5/1/15. Also there were 2 expired 1000 ml bags of Lactated Ringers with an expiration date of 8/1/15. It was verified with the Supply scan supervisor that his staff is responsible to check stock for outdates. He shared this finding with the person responsible for checking the stock the day of the survey, 8/12/2015. The following instructions were shared with the Rehab staff on the day of the survey, 8/12/2015: Prior to replacing a supply scan item back into stock (i.e. IV solutions), and removing a supply scan item, the expiration date must be checked. The Director has assigned the clinical supervisor to check the IV fluids each week for 8 weeks. If there are not outdates, then IV stock will be checked monthly. Surgery Department: 2 of 2 crash carts contained expired medications. Expired items found in one (1) crash cart included 50% Dextrose with an expiration date of</p>		

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	<p>found in one (1) crashcart included 50% Dextrose with an expiration date of 8/1/15, Aminophylline with an expiration date of 8/1/15, and 2 vials of Heparin with an expiration date of 7/15/15. The second crash cart contained 2 vials of Aminophylline with an expiration date of 8/1/15. According to the crashcart checklists, the crashcarts had been checked for outdates on 8/5/15.</p> <p>8. During tour of the facility offsite Urgent Care beginning at 9:45 a.m. on 8/13/15, 1 tube of Gentamicin ophthalmic ointment with an expiration date of 2/10/15 was located in procedure room 2. At the time of observation, staff member #N02 (Charge Nurse) threw the expired tube of ointment in the regular patient trash within the procedure room.</p>		<p>8/1/15, Aminophylline with an expiration date of 8/1/15, and 2 vials of Heparin with an expiration date of 7/15/15. The second crash cart contained 2 vials of Aminophylline with an expiration date of 8/1/15. According to the crash cart checklists, the crash carts had been checked for outdates on 8/5/15. Surgery has specifically assigned the responsibility for checking outdates on all crash carts within their department. If the responsible person is not available then another associate will be assigned. This process began in August 2015. The 3 crash carts have been added to the monthly Surgery Outdate Log. Surgery has also worked with Pharmacy to include modeling the medication tray replacements identical to the inpatient departments, which has been a very successful process. Epworth Urgent Care: Gentamicin ophthalmic ointment with an expiration date of 2/10/15 was located in procedure room 2. At the time of observation, staff member threw the expired tube of ointment in the regular patient trash within the procedure room. A pharmacist or a pharmacy technician, under the supervision of a pharmacist, conducts quarterly inspections of all off-campus outpatient departments, where medications</p>		

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S 1118 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (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:		are dispensed, administered, or stored. A record of all such inspections is maintained. All medications noted to expire prior to the next pharmacy inspection are tagged. The Urgent Care staff had not informed Pharmacy of the presence of medications in the procedure room in the locked cabinet. The Urgent Care staff checked all of the medications in the procedure room for expirations, the week of the ISDH visit. Pharmacy had added this area to be checked on their next visit. Between these site inspections, it is the responsibility, of the clinical staff, to observe for outdates and dispose of the expired medications, per policy. The Clinical Supervisor of Urgent Care Epworth reviewed the process for expired medications with the staff beginning the day of the survey and each day thereafter until all staff had received the information. The policy, Medication Storage, was posted the week of 9/21/2015 and required staff signatures.		

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S 1124 Bldg. 00	<p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the hospital created a condition that may result in a hazard by not securing 3 medical gas cylinders/tanks in the medical gas storage area.</p> <p>Findings:</p> <p>1. On 8/11/15 between 1pm and 4pm, during tour of the physical plant, in the medical gas storage room, the following was observed: 2 large unsecured cylinder type tanks labeled as oxygen and 1 unsecured medium sized tank tabled as carbon dioxide.</p> <p>2. On 8/11/15 at 2:15pm, S2, Facility Manager, indicated all gas storage tanks should be secured from tipping by use of chains or a storage cart. A policy for storage was requested at that time. Documentation was not received prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall hospital</p>			S 1118	<p>On 9/15/2015, the Director of Respiratory Therapy sent an email to the director over our medical gas supplier, asking him to remind his delivery staff to ensure all H-cylinders/tanks are secured with the chains when they exchange tanks/cylinders in the gas house. A log has been developed for our medical gas storage room to be checked twice a week to ensure proper securing of the medical gas tanks and cylinders. If a cylinder is found to be unchained or chained improperly, it will be immediately secured. If we find that there is a pattern for unsecured tanks, every effort will be made to identify the issue and disciplinary action may be taken, as appropriate.</p>		09/16/2015

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	<p>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>(A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.</p> <p>Based on document review, observation and interview, the facility failed to maintain patient equipment to ensure its operational safety.</p> <p>Findings:</p> <ol style="list-style-type: none"> Biomedical policy 1590648 indicated it is the facility's mission to provide a safe and clinically excellent environment for all Associates and those we serve each day. On 8/12/2015 at 1230 hours, accompanied by staff member A2, risk manager, while touring the inpatient physical and occupational "joint care" unit, the following was noted: <ol style="list-style-type: none"> The wooden steps used for patient 	S 1124	<p>Inpatient physical and occupational "joint care" unit: the wooden steps used for patient strengthening lacked an asset or other tag. There is no scheduled preventative maintenance. This has been added to the annual Periodic Maintenance log for an annual periodic maintenance check by our Biomedical Equipment staff. Physical Therapy will observe and report any issues between the annual checks, placing a work order. The steps will be removed from clinical use until repaired. The interim Director of Biomed/Equipment is taking an inventory of all wooden steps within the hospital and outpatient departments. This occurred on 9/22/2015. All steps used by Physical and Occupational</p>	09/23/2015			

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	<p>strengthening lacked an asset or other tag. Staff member #C3 indicated that staff tighten its screws when it gets loose, but there is no scheduled preventative maintenance.</p> <p>b. The stove and oven used in the occupational therapy area lacked asset tags and evidence of preventative maintenance.</p> <p>3. Staff member A2 concurred with these findings.</p>		<p>Therapy will receive an annual maintenance check. Occupational therapy area: the stove used lacked asset tags and evidence of preventative maintenance. The stove has received a maintenance check in 8/2015 The stove's asset tag number has been added to the equipment list for annual maintenance.</p>		