

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150026	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2015
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NAME OF PROVIDER OR SUPPLIER IU HEALTH GOSHEN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 200 HIGH PARK AVE GOSHEN, IN 46526
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S000000	The visit was for a licensure survey. Facility Number: 005025 Survey Date: 1-5/7-15 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Steve Poore, BS MLT Medical Surveyor 3 QA: clauglin 02/05/15	S000000		
S000322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (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: (H) Requiring all services to have policies and procedures that are			

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

TITLE

(X6) DATE

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

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	<p>updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to follow its policy/procedure and ensure that all policy/procedures in use were updated and/or reviewed at least every three years for 9 of 10 pharmacy policy/procedures and 5 of 5 environmental services (EVS) documents provided for review.</p> <p>Findings:</p> <p>1. The administrative policy titled Policies / Procedures [Approval of] (reviewed 12-12) indicated the following: "All policies and procedures are to be approved by the appropriate parties before implementation ...All policies and procedures will be reviewed at least every three years or earlier ...Policies must follow the attached format (page 4)."</p> <p>2. Review of pharmacy department policy/procedures indicated that the following policies had not been reviewed within the past three years: Medication Management (revised 2-11), Formulary System (revised 3-11), Storage & Preparation of Medications (revised 8-07), Returned/Expired/Contaminated Medications (revised 12-03), Controlled Substances Dispensing and Receiving (revised 2-11), Documenting Pyxis</p>	S000322	<p>1-3 PharmacyThe policies and procedures in Pharmacy have been reviewed and now have dates of February 2015. Three of these are being forwarded to the P&T Committee for approval which meets on February 25, 2015 and all will be up-to-date.Reviewed and dated February 2015Formulary systemControlled Substances Dispensing and ReceivingControlled Substance LossAdverse Drug ReactionsMedication ErrorsResponsible person: Director, PharmacyReviewed and changes requires re-approval by P&T Committee:Medication ManagementReturned/expired/contaminated medicationsAutomatic Stop OrdersResponsible person: Director, PharmacyExpiration dates are now being put on P&Ps as a reminder of when review is due again. A master list of all policies is being created which will note expiration dates for monitoring all policies.Responsible person: Regulatory/PI Coordinator4-6 Environmental ServicesThe "Practice Guidance for Healthcare Environmental Cleaning", second edition has been approved for use by the Infection Control Committee on 1/26/15.Compliance to procedure is monitored by Environmental Services shift supervisors and the</p>	02/25/2015			

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	<p>Discrepancies (revised 2-11), Controlled Substance Loss (revised 2-11), Automatic Stop Orders (revised 2-11), Adverse Drug Reactions [ADR] (revised 2-11), and Medication Errors (3-11).</p> <p>3. During an interview on 1-06-15 at 1010 hours, the pharmacy director A14 confirmed that the department policy/procedures had not been updated and/or reviewed within the past three years.</p> <p>4. On 1-06-15 at 0930 hours, the PI coordinator A4 was requested to provide for department-specific policy/procedures on occupied and terminal patient room cleaning, occupied infected and terminal infected patient room cleaning, and terminal operating room (OR) cleaning by EVS staff.</p> <p>5. EVS documentation provided on 1-06-15 at 1640 hours by EVS manager A16 and EVS director A25 indicated that the information (pages 107 to 137) was obtained from a 2012 publication titled Practice Guidance for Healthcare Environmental Cleaning (Second Edition). Page 122 of the requested documentation indicated the following: "To ensure consistent quality of terminal cleaning and adequate staffing resources for infection prevention, a total facility</p>		<p>Manager.Responsible person: Manager, Environmental Services</p>	

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S000332	<p>cleaning standard should be agreed upon in advance by Environmental Services, Infection Prevention and Operations or Administrative Management." The manager A16 and director A25 were requested to provide documentation indicating the selected guidelines were approved for use as department policy and no documentation was provided prior to exit.</p> <p>6. During an interview on 1-07-15 at 1330 hours, the EVS manager A16 and EVS director A25 confirmed that the selected guidelines were not approved as EVS policies in accordance with the administrative policy on policies and no other documentation was available.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</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>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p>			
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	<p>Based on document review and interview, the facility failed to develop and maintain its policies and procedures and ensure that documentation of additional training and validation of competency for environmental services (EVS) personnel performing Operating Room (OR) terminal cleaning and disinfecting was available for 1 (A26) EVS personnel.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Cleaning Schedule (revised 6-12) failed to ensure that housekeeping personnel files contain competency verification for cleaning the surgical care areas as indicated in Recommendation VIII and IX of the Recommended Practices for Environmental Cleaning [page 269-270] per the <u>2014 Perioperative Standards and Recommended Practices</u> by the Association of PeriOperative Registered Nurses (AORN). 2. During an interview on 1-06-15 at 1640 hours, the EVS manager A16 and EVS director A25 indicated that EVS staff A26 was responsible for terminally cleaning the 9 OR suites in the surgery department. 3. Review of the personnel file for EVS 	S000332	<p>The Video called "Top to Bottom: Cleaning Operating and Procedure Rooms", and is produced by AHE. The videos are used for additional training for specialty areas. Although it was not documented in the colleague's HR file, this training was accomplished prior to being assigned to clean in the ORs. The videos used and dates accomplished have been added to the individual's HR file, as well as other training done within the department that was available in the EVS department files, but not in HR. Now it is located in both files. Validation of competency is accomplished with testing services that have been cleaned. The ORs are at 100% passing the tests for being free of organisms. Responsbile person: Manager, Environmental Services</p>	01/23/2015			

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S000394	<p>staff A26 on 1-07-15 at 0930 hours failed to indicate documentation of education and competency verification for OR terminal cleaning and disinfecting.</p> <p>4. On 1-07-15 at 1330 hours, the EVS manager A16 and EVS director A25 were requested to provide department documentation of additional training and periodic validation of competency for OR terminal cleaning and disinfecting by EVS staff A26 and none was provided prior to exit.</p> <p>5. During an interview on 1-07-15 at 1335 hours, the EVS manager A16 and EVS director A25 confirmed that no documentation of training and periodic competency validation for terminal OR cleaning by EVS staff A26 was available.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and</p>	S000394	A complete list of all contracts	03/31/2015			

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	<p>interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided, for 20 contracted services.</p> <p>Findings:</p> <p>1. On 1-04-15 at 1630 hours, a list of contracted services was received from the performance improvement (PI) coordinator A4. The list of services failed to indicate a service provider for air exchange certification, elevators, emergency generators, 4 fire prevention services, linear accelerator maintenance, 3 laundry services, 2 medical physics services, medical waste disposal, pest control, 3 radiologic equipment maintenance services, radiation (tomo) therapy equipment maintenance, and trash (non-hazardous) disposal.</p> <p>2. Review of facility documentation indicated the following: air exchange certification by CS1, elevator service by CS2, emergency generator service by CS3, [4] fire protection services by CS4, CS5, CS6 & CS7, linear accelerator service by CS8, [3] laundry services by CS9, CS10 & CS11, [2] medical physics services by CS12 & CS13, medical waste disposal by CS14, pest control services by CS15, [3] radiology equipment service by CS16, CS17 &</p>		<p>revealed over 600 items. The list provided during survey was abbreviated to list only items with "service" in the title or name. Therefore, an incomplete list was provided. A complete list is now available as of 1/16/15. This entire list will be reviewed to determine which of these items are service contracts. Once this review is completed, monitoring tools will be provided to the departments employing the contracted service. These departments will complete the monitoring tools for 1st quarter, 2015 and quarterly thereafter. These quarterly reports will go to PIPS and be summarized to the Board from PIPS. Initial monitoring tools will be out by the end of March, 2015. Additionally, a tool will be created to be completed by persons at the time of requesting or renewing all contracts to establish what will be monitored over the life of the contract so none get missed in the future. Responsible person: Contract Database Coordinator</p>		

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	<p>CS18, radiation therapy service by CS19, and waste disposal service by CS20.</p> <p>3. On 1-6-15 at 1310 hours, the PI coordinator A4 confirmed that the list of contracted services failed to indicate an emergency generator maintenance provider.</p> <p>4. On 1-6-15 at 1320 hours, the director of facilities A11 confirmed the list of contracted services failed to indicate a pest control provider.</p> <p>5. On 1-6-15 at 1325 hours, the biomedical supervisor A12 confirmed the list of contracted services failed to indicate a mammography equipment service provider.</p> <p>6. On 1-6-15 at 1330 hours, the biomedical supervisor A12 confirmed the list of contracted services failed to indicate a linear accelerator equipment service provider.</p> <p>7. On 1-6-15 at 1335 hours, the biomedical supervisor A12 confirmed the list of contracted services failed to indicate a computerized tomography (CT) equipment service provider.</p> <p>8. On 1-6-15 at 1430 hours, the biomedical supervisor A12 confirmed the</p>				

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	<p>list of contracted services failed to indicate two medical physics services and a portable C arm equipment service provider.</p> <p>9. On 1-6-15 at 1435 hours, the director of facilities A11 confirmed the list of contracted services failed to indicate an elevator service provider.</p> <p>10. On 1-6-15 at 1440 hours, the director of facilities A11 confirmed the list of contracted services failed to indicate a fire extinguisher service provider.</p> <p>11. On 1-6-15 at 1442 hours, the director of facilities A11 confirmed the list of contracted services failed to indicate a fire alarm panel service and certification provider.</p> <p>12. On 1-6-15 at 1450 hours, the director of facilities A11 confirmed the list of contracted services failed to indicate a fire sprinkler service and a backflow preventer service provider.</p> <p>13. On 1-6-15 at 1455 hours, the director of facilities A11 confirmed the list of contracted services failed to indicate a medical waste disposal service, a trash disposal service, and an air exchange certification service provider.</p>			

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S000406	<p>14. On 1-6-15 at 1500 hours, the PI coordinator A4 confirmed that the list of contracted services failed to indicate three laundry service providers.</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 facility failed to assure that 4 services (respiratory therapy, PICC line service, the off-site sleep lab and off-site wound center including hyperbaric therapy) were evaluated and reviewed through the QAPI program.</p> <p>Findings:</p> <p>1. The 2014 Performance Improvement Plan (approved 2-14) indicated the following: "The program addresses maintenance and improvement in service</p>	S000406	Not evaluating all services through the QA/PI Program. With the implementation of a LEAN program, much of the QA/PI activity has centered around this process and the ORYX/Core Measures of CMS. Other areas have not been monitored as closely as those included in these two large programs. All directors are being given a tool to complete to list what quality programs and performance indicators are followed, or can be followed in their departments. This is going out at the Director's meeting on February 26 and they will have until 3/20/15 to return them and	03/31/2015

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S000570	<p>provision issues in every department throughout IUHGH, including ... the IU Goshen Sleep Disorders Center, [and] the IU Goshen Wound Center ..." The plan lacked a provision indicating that all services including contracted services would be evaluated and reviewed through the QAPI program.</p> <p>2. QAPI program documentation available for review at the time of survey failed to indicate evidence of ongoing monitoring for the respiratory therapy department, PICC line service, sleep lab and wound center.</p> <p>3. During an interview on 1-07-15 at 1430 hours, the PI coordinator A4 confirmed that the QAPI program lacked documentation of ongoing monitoring for the respiratory therapy department, PICC line service, sleep lab and wound center and confirmed that no additional documentation was available.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least</p>		begin monitoring if they are not already. These reports will be sent to Performance Improvement/Patient Safety (PIPS) Committee for monitoring and through them up to the Board. Responsible person: Regulatory/PI Coordinator				

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	<p>quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention and control program.</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from nursing service.</p> <p>(D) A representative from administration.</p> <p>(E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on document review and interview, the pharmacist failed to attend 3 out of 5 infection control committee meetings for 2014.</p> <p>Findings:</p> <p>1. Review of the document "IU Health Goshen Infection Prevention Department Overview IP #002-06", with a last revised date of 1/23/12, indicated:</p> <p>a. On page three under "Infection Prevention Committee", it reads: "...There will be an interdisciplinary representation of members on the infection prevention Committee that includes at least the following: 1. Administration...5. Colleague/Employee Health...8. Infection prevention...10. Medical Staff 11. Nursing Services...12. Pharmacy..."</p>	S000570	<p>1 - 4: The Pharmacy Director attended the Infection Control Committee meeting on 1/26/15 and will continue to attend or send a replacement if he cannot attend. The committee meeting time has changed in 2015 which eliminated the conflict that used to prevent the Pharmacy Director from attending on a regular basis. Will monitor the attendance for the meetings for a total of six months to assure a pattern of attendance. Will complete monitoring 6/30/15. Responsible person: Infection Prevention Practitioner</p>	01/26/2015			

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S000596	<p>2. Review of the 2014 Infection prevention committee meetings on 3/24/14, 5/19/14, 8/25/14, 9/22/14, and 11/24/14 indicated that the pharmacist attended on 5/19/14 and 11/24/14.</p> <p>3. At 1:35 PM on 1/6/15, interview with staff member #53, the pharmacist, indicated:</p> <p>a. This staff member does not always have available time to attend the infection control committee meetings.</p> <p>b. It is believed that a meeting time change may have occurred and might make attendance easier.</p> <p>4. At 9:00 AM on 1/7/15, interview with staff member #43, the infection preventionist, indicated:</p> <p>a. Pharmacy is listed as an infection control committee member, per the document listed in 1. above, and is expected to attend meetings.</p> <p>b. Pharmacy representation was lacking at 3 of the 5 infection control committee meetings for 2014.</p> <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:</p>			

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	<p>(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 policy and procedure review, document review, observation, and interview, the infection control committee and infection preventionist failed to approve the EVS (environmental services) cleaning manual and policies, failed to ensure the approval of cleaning processes and the monitoring of off site, contracted, cleaning companies and failed to ensure documentation of the periodic review of sterilization processes and biological testing.</p> <p>Findings: 1. EVS policies reviewed included: Patient Room - Terminal Clean (section 5.9); Isolation Room - Terminal (section 5.7); Patient room - Occupied (section 5.10); Isolation room - Occupied (section 5.8) and Surgical Area - Operating Room (section 6.1), no policy numbers and no effective, reviewed, revised dates present/noted. 2. Review of the 2014 Infection</p>	S000596	<p>1 - 3: The policies and procedures used by Environmental Services come from the "Practice Guidance for Healthcare Environmental Cleaning", second edition. These were all approved by the Infection Control Committee on 1/26/15. This is completed. Responsible person: Manager, Environmental Services 4 - 5: The policies and procedures used by the contract service to clean our outpatient locations have been requested and will go to the March Infection Control Committee for review / approval. This will be monitored quarterly as part of the contract monitoring process. Responsible person: Infection Prevention Practitioner 6 - 7: The sterilization practices/processes and biologicals will also report at the March Infection Control Committee. A reporting schedule will be developed once the committee sees the data. This will be monitored in the Infection Prevention Committee. Responsible person: Manager, Surgical Services</p>	03/31/2015			

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	<p>prevention committee meetings on 3/24/14, 5/19/14, 8/25/14, 9/22/14, and 11/24/14 indicated:</p> <p>a. There was no discussion regarding the approval of the EVS manual used as cleaning policies for the hospital.</p> <p>b. There was no discussion related to off site monitoring of housekeeping activities by contracted companies.</p> <p>3. At 9:20 AM on 1/7/15, interview with staff member #43, the infection preventionist, indicated:</p> <p>a. The infection control committee did not give approval of the manual titled "Practice Guidance for Healthcare Environmental Cleaning" that EVS is using as their cleaning policies.</p> <p>b. The hospital's infection control plan is ineffective if there is no oversight as to how the facility is cleaned to maintain a healthy atmosphere.</p> <p>4. At 3:25 PM on 1/6/15, while on tour of "The Retreat" off site, in the company of staff member #40, the VP of nursing, it was observed in a housekeeping closet a product called "Neutral 7 Neutral Cleaner" by Premier.</p> <p>5. At 9:25 AM on 1/7/15, interview with staff member #43, the infection preventionist, indicated:</p> <p>a. The infection control committee</p>			

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	<p>approved the chemical list for the contracted housekeeping company (Clearview) for use at The Retreat in March of 2014. (Policy # IP #068-02)</p> <p>b. There was no approval by the infection control committee of the contracted company cleaning processes, or documentation that the company would follow the hospital's processes for cleaning.</p> <p>c. The product "Neutral 7 Cleaner" is not a disinfectant and was not on the list of approved cleaning products for Clearview to use.</p> <p>d. It was unknown by the infection preventionist that the contracted housekeeping providers had been using the Neutral 7 product.</p> <p>e. There is no oversight of the contracted cleaners at off sites by the infection preventionist, or other infection control committee members, to be sure that the contracted cleaners are using hospital approved products and cleaning in a manner/process approved by the hospital and its infection control committee to assure cleanliness and asepsis of the off sites.</p> <p>6. Review of the Infection control committee meetings of 3/24/14, 5/19/14, 8/25/14, 9/22/14, and 11/24/14 indicated that there was no report of evaluation of sterilization practices/processes, nor of</p>			

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S000606	<p>biologicals results.</p> <p>7. At 9:00 AM on 1/7/15, interview with staff member #43, the infection preventionist, indicated:</p> <p>a. This staff member works with staff member #46, the OR (operating room) manager and SPD (sterile processing department) manager, in monitoring sterilization practices within the facility.</p> <p>b. There is no documentation of this collaboration, nor reporting to the infection control committee regarding the evaluation of these processes.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to</p>			

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	<p>determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on policy and procedure review, employee health record review, and staff interview, the infection control committee and infection preventionist failed to implement facility policies as relates to communicable disease immunity for 3 of 10 employees (N1, N9, and N10), and related to annual TB (tuberculosis) testing for 1 of 2 ED (emergency department) techs (N8).</p> <p>Findings:</p> <p>1. Review of the policy "Varicella Policy/Procedure for Colleagues", policy number IP #030-04 CH #012, with an effective date of 9/24/12, indicated:</p> <p>a. Under "Policy", it reads: "Healthcare workers employed by or working in IU Health Goshen will demonstrate immunity to varicella...".</p> <p>2. Review of the policy "Rubeola Policy/Procedure for Colleagues", policy number IP #026-05 CH #010, with an effective date of 5/20/13, indicated:</p> <p>a. Under "Policy", it reads: "Health care workers employed by or working in the IU Health Goshen System will demonstrate immunity to Rubeola."</p> <p>b. Under section I., it reads: "...A. Criteria for immunity: 1. Written</p>	S000606	<p>1 - 5: The Human Resources Department (HR) will review the records of all employees and develop a list of those whose varicella status is unknown and those whose rubeola status is unknown. This will be completed by 3/31/15. Responsible person: Director, HR</p> <p>When there is a community outbreak of either virus, the colleagues on the list will be relieved of duty until the outbreak is over. When Colleague Health is notified by the Infection Prevention Practitioner of an outbreak of either virus, Colleague Health will consult the list of those without immunity and contact all departments with involved colleagues. The Colleague Health Nurse will contact every colleague by phone of the outbreak, and to assist them with precautions if needed. Colleagues will remain off duty until the "all clear" is determined by the Chairman of the Infection Prevention Committee. Both policies will be updated. Responsible person: Colleague Health Nurse6 - 8: Staff member #44 who worked without completing the TB screening process - he has now had the test repeated and read. It was negative and he is now free to return to work. This is closed. Responsible person:</p>	12/31/2015	

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	<p>documentation of immunization with two doses of live measles or MMR vaccine administered at least 28 days apart or 2. Laboratory documentation that the individual has had rubeola, or 3. Laboratory documentation of a previous positive antibody titer..."</p> <p>3. Review of personnel files, specifically health files, indicated:</p> <p>a. RN (registered nurse) N1 was hired 12/13/10 and had a self reported history of having had Varicella.</p> <p>b. Specialty tech/nurse aide N9 was hired 1/11/10 and had a self reported history of having had Varicella.</p> <p>c. SPD (sterile processing department) employee N10 was hired 10/10/11 and had:</p> <p>A. A Rubeola titer that indicated they were non immune to the communicable disease (< 0.9 = "negative", per 10/10/11 lab results).</p> <p>B. A document noting that the employee declined the Rubeola vaccine on 3/26/12.</p> <p>4. At 9:15 AM on 1/6/15, interview with staff member #44, the human resources director, indicated:</p> <p>a. Verbal confirmation of having had Varicella as a child was accepted prior to the newest policy.</p> <p>b. The new Varicella policy was</p>		Director, HR				

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	<p>implemented 9/12 and staff members N1 and N9 were hired prior to that date.</p> <p>c. There was no requirement to review records for employees hired prior to that time, to go back and check for known immunity in the cases where verbal confirmation of having had the disease was given at the time of hire.</p> <p>5. At 9:25 AM on 1/6/15, interview with staff member #45, the colleague health nurse, indicated:</p> <p>a. This staff member repeated the responses, as listed in 4. a., b., and c. above.</p> <p>b. When an outbreak of communicable disease occurs and a patient is admitted/cared for at the hospital, it is determined what staff cared for the patient and to review their health files. If determined there is unknown, or no, immunity, the staff member would be encouraged to receive a booster for that disease.</p> <p>c. There is no list of unknown immune staff (N1 and N9), or non immune staff (such as N10 for Rubeola).</p> <p>d. If there is an outbreak in the community, non immune staff could be incubating a communicable disease and infecting both patients and other non immune staff making the current policies ineffective.</p> <p>e. Standard of practice is that those who</p>			

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	<p>have unknown immunity or known non immunity should be on a list or log, and relieved from work during the duration of a community outbreak of a particular communicable disease.</p> <p>6. Review of the policy "Mandatory TB Screening for Colleagues, Volunteers, & Physicians", policy number IP #023-06 CH #007, with an effective date of 9/23/13, indicated:</p> <p>a. Under "Procedure", it reads: "1. TB skin testing is an annual requirement that is mandatory for specific Colleagues, students, volunteers and physicians of Indiana University Health Goshen to screen for tuberculosis infection and disease...".</p> <p>7. Review of the employee health file for ED tech N8 indicated that their last TB test was given 12/23/14 and read on 12/26/14.</p> <p>8. At 9:15 AM on 1/6/15, interview with staff member #44, the human resources director, indicated:</p> <p>a. Program directors for each department are notified when staff are delinquent, such as N8 for receiving their annual TB test.</p> <p>b. Staff member N8 has not been relieved of their work duties, as they last worked on 1/3/15.</p>						

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S000608	<p>c. Staff member N8 should not have been scheduled to work after 12/26/14, due to the delinquency of their annual TB test.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on policy and procedure review, observation, and interview, the infection control committee and infection preventionist failed to ensure the implementation of policy related to surgery area dress code in regard to surgical masks for 4 staff observed.</p> <p>Findings:</p>	S000608	1 - 6: All staff were re-educated on the dress code and that masks are to be discarded when a case is concluded at the January staff meeting of Surgical Services. Monitoring will be done the the Manager Responsible person: Manager, OR	01/19/2015	

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	<p>1. Review of the policy "Dress Code" for the departments of "OR (operating room), PACU (post anesthesia care unit), Day Surgery", with no policy number, and last revised 3/14, indicated:</p> <p>a. On page one under "Guidelines", it reads in item #8., "...b. Masks should either be worn on the face or removed. They are not to hang around the neck or be placed in a pocket to be used later...".</p> <p>2. At 10:30 AM on 1/6/15 while on tour of the OR area in the company of staff members #40, the VP of nursing, and #55, the manager/director of surgical, heart and vascular services, it was observed that 2 surgically clad staff members were walking in the hallway between Day Surgery and PACU with surgical masks hanging down about the neck.</p> <p>3. At 10:40 AM on 1/6/15 while on tour of the OR area in the company of staff members #40, the VP of nursing, and #55, the manager/director of surgical, heart and vascular services, it was observed that one male surgical staff member had their mask down about the neck in the hallway, entered an OR room (with a procedure in progress) and put their mask back up over their face.</p> <p>4. At 11:15 AM on 1/6/15 while on tour</p>			

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S000612	<p>of the OR area in the company of staff members #40, the VP of nursing, and #55, the manager/director of surgical, heart and vascular services, it was observed that one surgery staff member was in the PACU with their surgical mask down about the neck.</p> <p>5. At 10:30 AM on 1/6/15, interview with staff member #55 indicated that it's OK for surgery staff to have a mask down about the neck, but not to re use it during a new case.</p> <p>6. At 11:25 AM on 1/6/15, interview with staff member #40 indicated that facility policy requires that surgical masks not be left down about the neck and that surgical staff should be monitored regarding this.</p> <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</p>						

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	<p>limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling. Based on observation and interview, the infection control committee failed to develop and maintain a laundry management plan for items laundered at the facility.</p> <p>Findings:</p> <p>1. On 1-07-15 at 1305 hours, during a tour of the support services areas of the facility, the following condition was observed in the environmental services supply room: two washing machines and two clothes dryers without a degree of separation and without a point of use hot water heater and/or a thermometer or temperature display to determine the hot water wash temperature. The EVS manager A16 and EVS director A25 were requested to provide documentation of hot water temperature monitoring and/or evidence that the infection control committee had recommended specific chemical detergents for use in low-temperature washing (<160o F [<71oC]) if low temperature laundry cycles were used ... [per the Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee</p>	S000612	<p>1 - 2: IUHGH has stopped laundering any items and is sending the curtains to our laundry vendor with all other items. The only items that were previously washed on-site were privacy curtains. The washer and dryer will no longer be used. Responsbile person: Manager, Environmental Services If IUHGH were to resume curtain laundering activity, the water temperature will be recorded on a log to demonstrate that the water does get hot enough. This log will be maintained by the washing machine. Research is being conducted to find a washer with the ability to read and display water temperature. This will be dependent on finding an affordable unit. If an affordable option is not found, the curtains will continue to be sent out with the rest of the laundry. Resonsible person: Manager, Environmental Services</p>	01/08/2015			

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S000840	<p>(HICPAC)[page 139]. 2003 Centers for Disease Control and Prevention (CDC)] ...and no documentation was provided prior to exit.</p> <p>2. During an interview on 1-07-15 at 1305 hours, the EVS manager A16 and EVS director A25 confirmed that no hot water temperature monitoring was being performed for the washing machines and confirmed that no documentation of the infection control committee recommendation, selection or approval for the laundry detergent currently in use for washing patient room privacy curtains was available.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (b)(2)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(2) be reviewed at least triennially; and Based upon document review and interview, the governing board failed to ensure that the the medical staff bylaws were reviewed and approved by the medical staff and governing board at least every three years.</p>	S000840	1 - 2: The Medical Staff has requested a review by an independent consultant to do a more thorough Bylaws review. A vendor has been selected and accepted the job. The Bylaws were mailed out to this group earlier this month. It is expected	06/30/2015			

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S000912	<p>Findings:</p> <p>1. The Medical Staff Bylaws and Related Manuals (last Board approval 6-28-11) indicated the following: " Bylaws Review: The medical staff bylaws will be reviewed at least every three years ...Adopted by the Medical Staff on April 12, 2011. "</p> <p>2. During an interview on 1-06-15 at 0940 hours, the medical staff coordinator A6 confirmed that the medical staff bylaws had not been reviewed by the medical staff and approved by the governing board within the past three years.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary</p>		to be returned in 6-8 weeks. It will then require both the Medical Staff and Board of Directors approval. New Bylaws are expected to be completed by June, 2015 if not sooner. Responsible person: Manager, Medical Staff Services				

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	<p>to provide care for all patient care areas of the hospital.</p> <p>(ii) Maintaining a current nursing service organization chart.</p> <p>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.</p> <p>(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.</p> <p>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, medical record review, observation, and interview, the nurse executive failed to ensure the implementation of policies related to: the measuring of head circumference for 2 of 2 pediatric patients (#10 and #11), follow up after pain medication was given for 1 of 2 C-Section patients (#12), the lack of documentation on the admission consent indicating that patient rights information was given to patients on admission for current OB patients (4 of 4 records: #6, #7, #8 and #9), for 1 of 1 oncology admission patient (#22), for one closed OB patient (#12), and for one closed newborn record (#19), dating glucometer control solutions when opened (in Day Surgery area) and failing to maintain a</p>	S000912	<p>1 - 3: Head Circumference measurement and documentation is being changed in the Assessment procedure to only be required on children age 24 months or less. It is not a useful measure after that age. The policy will also be moved from the Administrative Manual to the Nursing Manual so clinical staff can easily locate it. The entire policy and procedure are being reviewed/revised and will be completed by 3/31/15. Clinical staff will be educated on the new Policy and procedure and new location in the month of April. Then a monitor of pediatric charts will be reviewed in May and June to assure compliance to documenting head circumference. Responsible person: VP, Nursing Services4 - 6: Education refresher on the</p>	06/30/2015

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	<p>clean pantry refrigerator in one unit toured (4 West).</p> <p>Findings:</p> <p>1. Review of the policy "Patient Assessment", no policy number, last revised 2/13, indicated:</p> <p>a. Under "Individual Assessment", on page one, it reads: "...When an infant, child or adolescent is being treated, at least the following additional areas will be assessed:...The patient's developmental age, length or height, head circumference and weight...".</p> <p>2. Review of two open records for patients on 4 West indicated:</p> <p>a. Pt. #10 was a 7 month old admitted on 1/6/15 who lacked documentation of a head circumference being measured on admission as part of the admission assessment.</p> <p>b. Pt. #11 was a 1 year, 10 month old child admitted on 1/5/15 who lacked documentation of a head circumference being measured on admission as part of the admission assessment.</p> <p>3. Interview with the VP of nursing, staff member #40, at 12:15 PM on 1/7/15 indicated that per facility policy, head circumference checks are to be done on admission for pediatric patients, and those are missing for patients #10 and</p>		<p>expected documentation on pain relief by the end of March (3/31/15) for all patient care areas. Then review 30 charts/month for three months to assure compliance (Apr-Jun). To Nursing Quality Council for action on the results of monitoring if non-compliant. Responsible person: VP, Nursing Services7 - 11: The Admission Consent form has been redesigned to accomodate better the activity that occurs at registration. There is now a series of choices to the question "I've received the booklets explaining patients' rights / responsibilities..." () yes () no () declined - which will make it clearer to others why the patient did not receive a copy in every case. It is often refused when patients have been here in the past, they already know their rights. Since there was no place to document refusal, the () yes was left blank because it was not given. Education is being conducted on the revised form during the final week of February and the new consent will be implemented 3/2/15. A review of 30 cases per month will be done in Mar - May to assure compliance to issuance of the patients' rights information. Responsible person: Manager, Registration12 - 14: New stickers being printed for glucometers to remind staff to date control solution. Remonitor after stickers have been placed to</p>				

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	<p>#11.</p> <p>4. Review of the policy "Pain Relief" (a "Mosby's Skills" document), no policy number, dated 9/2014, indicated:</p> <p>a. On page one in the "Alert" section, it reads: "Each patient should be assessed for pain every 8 hours. If the patient is experiencing pain assess every 4 hours and within 1 hour after each pain intervention...".</p> <p>5. Review of the closed C-Section medical record (#12) indicated:</p> <p>a. A C-Section was performed on 12/2/14 with Norco ordered for relief of pain.</p> <p>b. Norco was given at 12:28 AM on 12/3/14 with follow up documented at 3:46 AM.</p> <p>c. Norco was given at 6:40 AM on 12/3/14 with follow up noted at 9:06 AM.</p> <p>d. Norco was given at 1423 hours on 12/3/14 with no follow up reassessment documented.</p> <p>6. At 2:55 PM on 1/7/15, a re-review of the medical record for pt. #12 with the VP of nursing, staff member #40, indicated that nursing staff did not follow facility policy with follow up reassessment within one hour of pain intervention for the patient.</p>		<p>assess compliance. Laminated notices with the manufacturers recommendations are now affixed to all glucometer cases. Monitor solution bottles on floors for 3 months to assure compliance. (Mar-May).Responsible person: VP, Nursing Services15 - 20: Added this responsibility to the USNA duties to clean on a weekly basis as of 2/9/15. Add to Environment of Care Rounds to check when they are rounding to assure compliance. Responsible person: VP, Nursing</p>				

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	<p>7. Review of the policy "Patient Rights and Responsibilities", no policy number, last reviewed 6/13, indicated:</p> <p>a. Under "Scope", on page one, it reads: "...Patients have a right to: 1. The appropriate level of care/service within the hospital's capacity. 2. Information about their rights: receive Patient Bill of Rights at registration...".</p> <p>8. Review of open OB patient (and newborn) medical records of patients #6, #7, #8 and #9 indicated that none of the forms "Admission/Treatment Consents, Releases, Authorizations, and Acknowledgments" had the area "#7. Patients Rights" completed in regarding the statement: "I have received the booklets explaining patients' rights/responsibilities, which includes "About Patients Rights and Your Right to Decide" "Yes ___ NO ___".</p> <p>9. Review of closed patient medical records indicated that patients #12, #19 and #22 were also lacking documentation on the form "Admission/Treatment Consents, Releases, Authorizations, and Acknowledgments" in section #7.</p> <p>10. At 11:00 AM on 1/7/15, while reviewing open records on the OB unit in the company of staff member #40, the VP</p>						

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	<p>of nursing, interview indicated that nursing staff complete the registration process on this unit and that staff need to be retrained/educated regarding completion of section #7 of the admission/consent form.</p> <p>11. At 2:15 PM on 1/7/15, interview with staff members #58 and #59, two RNs (registered nurses) and Meditech specialists (facility computer system for medical records) indicated agreement that the consent forms for pts. #12, #19 and #22 were lacking completion of section #7 of the admission/consent for treatment.</p> <p>12. Review of the policy "Glucometer, Whole Blood Glucose by Accu-Chek Inform II, Point of Care Testing", no policy number, last approved on 12/14, indicated: a. On page 3 under "2. Accu-Chek Inform II Control Solutions", it reads: "...b. Stability 1) Control solutions are stable for three months after opening...3) The date the vial is opened must be written on the vial label as well as the 3 month discard date...".</p> <p>13. At 11:10 AM on 1/6/15, while on tour of the Day Surgery area in the company of staff member #48, the Day Surgery manager, it was observed that the</p>						

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	<p>glucometer control solutions (two vials) had no documentation written on the vials of a date opened, or a 3 month expiration date.</p> <p>14. At 11:10 AM on 1/6/15, staff member #48 agreed that nursing staff had failed to note on the solution vials the opened and expiration dates, as required per facility policy.</p> <p>15. At 12:10 PM on 1/7/15, while touring the 4 West medical/peds nursing unit in the company of staff member #60, the director of med/surg and peds, it was observed in the clean utility room that the pantry refrigerator had spilled dried liquids present on the interior of the door and shelf units, and under the glass shelves, it was dirty where they came in contact with the ledges they were resting upon.</p> <p>16. At 12:10 PM on 1/7/15, interview with staff member #60 indicated the cleaning of the refrigerator is dietary's responsibility.</p> <p>17. At 1:00 PM on 1/7/15, interview with staff member 42, the director of performance improvement, indicated that dietary reports they are not responsible for pantry refrigerator cleaning, but that EVS (environmental services) is</p>			

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S001014	<p>responsible.</p> <p>18. At 1:40 PM on 1/7/15, interview with staff members #51, the EVS director, and #52, the EVS manager, indicated that housekeeping/EVS is not responsible for cleaning pantry refrigerators.</p> <p>19. At 2:30 PM, interview with staff member #51, the EVS director, indicated that per a phone call with the infection preventionist, there is no infection control policy related to the cleaning of pantry refrigerators.</p> <p>20. At 2:35 PM on 1/7/15, interview with staff member #40, the VP of nursing, indicated:</p> <p>a. There is no facility policy related to refrigerator cleaning.</p> <p>b. It appears that no one is assigned to clean pantry refrigerators as several departments were under the impression that other departments were responsible.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling,</p>						

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	<p>storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on policy and procedure review, observation, document review, and staff interview, the pharmacy director failed to ensure the implementation of policy related to the number and placement of Dantrolene Sodium through out the hospital, and failed to implement pharmacy policy related to the monthly checks of medication storage areas.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the policy "Malignant Hyperthermia (Perioperative)" (from "Mosby's skills"), no policy number, reviewed/revised July, 2014, indicated: <ol style="list-style-type: none"> In the "alert" section at the top of page one, it reads: "...1. Dantrolene Sodium location at IUHGH (Indiana University Health Goshen Hospital) a. 12 vials OR (operating room) MH (malignant hyperthermia) Cart b. 12 vials CCB (obstetrics unit) MH Cart c. 6 vials ICU (intensive care unit) pyxis "Over-ride" d 6 vials Pharmacy...". While on tour of the OR area at 10:40 AM on 1/6/15, it was observed that 12 vials of Dantrolene were present in the MH Cart. While on tour of the CCB OR area at 	S001014	<p>1 - 5: 6 additional vials of Dantrolene have been obtained (for a total of 36) and the policy has been revised to correctly document where these are stored. 12 in OR Malignant Hyperthermia Cart 12 in Delivery Room Malignant Hyperthermia Cart 12 in Pharmacy Pharmacy will check quantities with rounds for expired product. Responsible person: Director, Pharmacy 6 - 10: Pharmacy has resumed monthly rounds in all medication locations. All units brought up-to-date in February and a schedule to assure all are checked monthly from now forward. Pharmacy will report accomplishment of expiration rounds at P&T Committee. Responsible person: Director, Pharmacy</p>	01/28/2015

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	<p>11:00 AM on 1/6/15, it was observed that 12 vials of Dantrolene were present in the MH Cart.</p> <p>4. A visit to the ICU at 11:15 AM on 1/6/15 indicated there was no Dantrolene found in the pyxis on that unit.</p> <p>5. At 11:20 AM on 1/6/15, interview with the VP of nursing, staff member #40, indicated:</p> <p style="padding-left: 20px;">a. A phone call to the pharmacy at 11:20 AM on 1/6/15 indicated there were 6 vials of Dantrolene in the pharmacy.</p> <p style="padding-left: 20px;">b. It was unknown, by this staff member and by pharmacy, that there were to be 6 vials of Dantrolene in the ICU.</p> <p style="padding-left: 20px;">c. There are only 30 vials of Dantrolene in the hospital, not 36, as required by facility policy.</p> <p>6. Review of the policy "Inspection of Medication Storage Areas", no policy number, last revised 9/03, indicated:</p> <p style="padding-left: 20px;">a. Under "Policy", it reads: "Medications stored within the pharmacy and throughout the IU Health Goshen system are under the supervision of the Pharmacy Department. All medication storage areas shall be inspected monthly by a pharmacy colleague or designee for appropriate storage conditions (including security) and expired medications."</p>			

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S001172	<p>7. At 2:30 PM on 1/5/15, while touring the ED (emergency department) in the company of staff member # 49, the ED director, it was observed in the Braslow, pediatric emergency cart, that 2 Pediatric Sodium Bicarb packages had expired 1/1/15.</p> <p>8. At 10:35 AM on 1/6/15, while on tour of the Cath lab OR #3, it was observed in the medication cart that 2 one ml single dose vials of Naloxone HCL had expired 1/1/15.</p> <p>9. At 1:35 PM on 1/6/15, the document titled "Unit Inspection Checklist - Technicians" was reviewed and indicated the Cath lab and ED (along with 7 other units) had not had monthly medication cart checks completed since May 2014.</p> <p>10. At 1:35 PM on 1/6/15, interview with the pharmacist (staff member #53) agreed that the areas listed in 9. above have not been checked by pharmacy since May of 2014, as required per facility policy.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and</p>						

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	<p>furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on policy and procedure review, observation, and interview, the facility failed to ensure that environmental services were provided in a such a way as to guard against the transmission of disease in regard to dusty areas in 5 areas toured, and failed to ensure that housekeeping staff were mixing the approved cleaning product as per manufacturer's instructions.</p> <p>Findings:</p> <p>1. Review of the policy "Surgical Area - Operating Room", section 6.1 of the EVS (environmental services) cleaning manual, (no policy number and no indication of approval date), indicated:</p> <p>a. On page 134, it reads in item 18., "Clean air intake grills, ducts, and filter covers as they must be kept free of lint and dust...".</p>	S001172	<p>1 - 3, & 5: Dust on intake grills of the ventillation system will be cleaned by the Environmental Services Staff in all areas. They will be reminded that this in part of the room cleaning process. The Manager of EVS will check for cleanliness of face plates to the ventillation system in all procedural rooms in April to assure they are included in cleaning. Responsible person: Manager, Environmental Services</p> <p>4, 6 - 7: Dust on Nursing Equipement not frequently used will be addressed in a task force in the month of March for implementation in April to create a process to assure this is made part of the routine for all departments that store medical equipment. Monitoring via checklist will be established with the process design. Responsible person: Regulatory/PI Coordinator</p> <p>8 - 11: Re-education of Environmental Services staff</p>	04/30/2015			

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	<p>2. At 9:55 AM on 1/6/15, while on tour of the GI (gastrointestinal)/endoscopy area in the company of staff member #46, the OR (operating room) manager, it was observed that room #1 had dust on the back of the Erbe (electro cautery) machine and on the wall mounted ventilation face plate.</p> <p>3. At 10:35 AM on 1/6/15, while on tour of the Cath lab OR #3 in the company of staff member #50, the cath lab manager, it was observed that the wall mounted ventilation face plate had dust on the louvers.</p> <p>4. At 10:24 AM on 1/7/15, while on tour of the OB (obstetrics) unit in the company of staff member #54, the ob manager, it was observed in rooms 301 and 314 that the fetal heart monitors were dusty on the tops of the back half of the machines.</p> <p>5. At 11:25 AM on 1/7/15, while on tour of the nursery in the company of staff member #54, the OB manager, it was observed that the wall mounted air return face plate (on the lower wall portion left side of the nursery as exiting the room) had an accumulation of dust present.</p> <p>6. At 11:40 AM on 1/7/15, while on tour of the 4 West medical/peds nursing unit</p>		<p>on mixing solutions. Provided the guides for mixing on each EVS cart and in EVS closets for reference as it is needed. 1/28/15 completed. Responsible person: Manager, Environmental Services</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>in the company of staff member #40, the VP of nursing, it was observed that:</p> <ul style="list-style-type: none"> a. The top of the code cart (behind the defibrillator) had an accumulation of dust present. b. The lower ledges of the code cart were dusty (shelf type area above the wheels). c. The top of the peds cart (behind the respiratory box) had an accumulation of dust present. <p>7. At 1:40 PM on 1/7/15, interview with staff members #40, the VP of nursing, #51, the director of EVS (environmental services), and #52, the EVS manager, indicated:</p> <ul style="list-style-type: none"> a. Air ventilation duct work/face plates are the responsibility of EVS staff in their cleaning process. b. The tops of code carts and fetal heart monitors are the responsibility of nursing staff in maintaining cleanliness. <p>8. At 2:35 PM on 1/5/15, while on tour of the ED (emergency department), review of the label for the housekeeping product Oxy Complete indicated that 1/2 ounce/gallon in cold water was to be used on routine floor cleaning and 1 ounce/gallon was to be used for restroom floor cleaning.</p> <p>9. At 10:50 AM on 1/7/15, while on tour</p>						

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	<p>of the OB unit (CCB), the housekeeper (#56), indicated that no specific measurements of Oxy Complete are used in mixing the product in "about 4 quarts or 3.6 liters".</p> <p>10. At 11:40 AM on 1/7/15, while on tour of the 4 West nursing unit, the housekeeper (#57), indicated that almost 2 oz/gallon of water are used (of the Oxy Complete) in mixing the product for cleaning.</p> <p>11. At 1:40 PM on 1/7/15, interview with staff members #40, the VP of nursing, #51, the director of EVS, and #52, the EVS manager, indicated housekeeping staff need further education in the ratio of Oxy Complete and water for appropriate cleaning and disinfection.</p>				