

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|------------------------|--|--------|--|------------|
| S 0000 Bldg. 00 | This visit was for a State licensure survey. Facility Number: 005009 Dates: 3/28/16 to 3/30/16 QA: cjl 05/04/16 IDR Committee Meeting Held on 07-27-16, Tag S1118 modified. JL | S 0000 | | |
| S 0406 Bldg. 00 | 410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and | S 0406 | | 06/01/2016 |

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

TITLE

(X6) DATE

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

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>interview, the hospital failed to have an effective organized, hospital-wide quality assessment and improvement program in which 8 services (dental, infusion therapy, laundry, pediatrics, post-operative recovery, EMG (electromyography), off-site radiology and outpatient surgery services) were not included and failed to include measures for 4 services (audiology, endoscopy, medication errors, PET (positron emission tomography) scans).</p> <p>Findings:</p> <p>1. Review of the document titled Quality Improvement Plan 2016, approved 1/5/16, indicated the following: Scope:</p> <p>a. The Hospital uses the DMAIC (define, measure, analyze, improve, control) model...</p> <p>b. Quality Plan Objectives: Utilize the ... Quality Dashboard as a reporting system for ongoing measurement of performance improvements.</p> <p>c. The Quality Improvement Plan encompasses all departments, services and functions at the hospital.</p> <p>d. All PI (performance improvement) activities will follow a planned, systematic, organization-wide approach involving the appropriate departments, services and disciplines.</p> <p>e. Measure (DMAIC): Measurement</p> | | <p>Quality Monitoring will be reported to the Safe Practice Quality Council at a minimum of once per year and more frequently if issues arise.</p> <p>Dental Services: Monitor that each patient is covered with a lead apron during all dental procedures when x-ray is used. This will be incorporated with documentation in the patient's chart.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: 100%</p> <p>MONITOR: 100% of dental patient charts</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Director of Surgical Services</p> <p>Infusion Therapy: Monitor Smart Pump compliance to ensure pump is in drug library and medication is infusing correctly per following physician orders.</p> <p>DATE CORRECTED: 3-31-16</p> <p>GOAL: 90% compliance</p> <p>MONITOR: 10% of pumps in use</p> <p>FREQUENCY: Monthly</p> | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>will be systematic, related to relevant dimensions of performance and be of appropriate scope and frequency.</p> <p>f. In addition to the Performance Improvement Teams, the following key processes will be monitored and measured: (the following list is not all inclusive) Surgical and Invasive Procedures (discrepancies between pre-postoperative diagnoses), Use of Medications/Adverse Drug Reactions/Significant Medication Errors, Outpatient Core Measures.</p> <p>2. Review of Quality dashboards, quality committee meeting minutes and departmental data collection sheets from 1/2015 to 2/2016 indicated lack of documentation of hospital quality monitoring for dental services, infusion therapy, laundry, pediatrics, post-operative recovery, EMG, off-site radiology and outpatient surgery services.</p> <p>3. Review of 1/2015 to 2/2016 data type documents of the following indicated lack of evidence of quality measures: audiology, endoscopy, medication errors, PET scans.</p> <p>4. On 3/30/16 at 1:15pm, A10, Chief Nursing Officer (CNO), indicated not all service/department reports are monitored by the Quality committees on a regular</p> | | <p>RESPONSIBLE: Nurse Manager 2SE & IV Therapy</p> <p>Laundry: Linens are inspected upon delivery to hospital. Linens with abnormalities (torn, stained, etc.) are placed in a bin marked "Return to Credit."</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: 10% or less return rate</p> <p>MONITOR: 100% of linens delivered</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Director of Materials Management</p> <p>Pediatrics: Pediatric Medication Safety will be monitored by investigating all incident or near miss reports that are entered in the Midas System.</p> <p>DATE CORRECTED: 3-31-16</p> <p>GOAL: 100% Compliance</p> <p>MONITOR: 100% Midas Entries</p> <p>FREQUENCY: Monthly and ongoing</p> <p>RESPONSIBLE: Director of Women's Care Place and Manager of Emergency Services</p> | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>basis, but if a problem presents, department directors monitor and report up to the Vice President/CNO.</p> <p>5. On 3/30/16 at 3:30pm, A1, Director of Quality/Risk/Compliance, indicated the hospital lacked documentation of quality monitoring of dental services, infusion therapy, laundry, pediatrics, post-operative recovery, EMG, off-site radiology and outpatient surgery services and did not show measurable monitors for departmental data collected on audiology, endoscopy, medication errors or PET scans.</p> | | <p>Post-Operative Recovery: Pain control goal for post procedure to be set by patient in pre-op using 1-10 pain scale. Pain will be monitored in post-op using same scale. 90% of patients will meet or exceed pain control goals. Documentation will be maintained in the patient's medical record.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: 90% Compliance</p> <p>MONITOR: 30 charts per month</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Director of Surgical Services</p> <p>EMG: Monitor number of repeat procedures due to being non-diagnostic.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: zero</p> <p>MONITOR: 100% of procedures</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Director of Cardiology/Medical Imaging</p> <p>Radiology off site: Monitor the repeat test rate to determine where</p> | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>quality improvement is needed.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: 6% or less repeat rate</p> <p>MONITOR: 100% of procedures</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Director of Cardiology/Medical Imaging</p> <p>OP Surgery: Monitor that all consents are signed and filled out appropriately prior to procedure. Will audit 15 consents per month with a goal of 100%</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: 100%</p> <p>MONITOR: 15 charts per month</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Director of Surgical Services</p> <p>Audiology: This is a contract service. The company will send reports of number of patients sent for referral for follow up care for possible hearing difficulty/ loss. The number will be compared to national bench mark rates.</p> <p>This will be monitored quarterly by</p> | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>the Director of Women's Health Services.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: Results within 5% of national benchmark</p> <p>MONITOR: 100% of referrals</p> <p>FREQUENCY: Quarterly</p> <p>RESPONSIBLE: Director of Women's Care Services</p> <p>Endoscopy: Monitor for pain medication follow up assessment completed after procedure.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: 90% compliance</p> <p>MONITOR: 10 Charts per month</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Director of Surgical Services</p> <p>Medication Errors: Medical Errors are reported through the Midas System. Each Medical Error is Investigated by the Director of Pharmacy and Risk Manager at the time of the report to determine if immediate action is needed and/or review by Peer Review Committee or</p> | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| S 0554 Bldg. 00 | 410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and | | P&T Committee. Data is trended in Theradoc and reported to the P&T committee quarterly. DATE CORRECTED: 6-1-16 GOAL: 100% of Reports Investigated MONITOR: 100% of reports FREQUENCY: Quarterly RESPONSIBLE: Director of Pharmacy PET Scan: This is a contract service. Repeat Scans will be monitored. Reports sent to hospital quarterly. DATE CORRECTED: 6-1-16 GOAL: Less than 1.8% of scans will require a repeat scan MONITOR: 100% of procedures FREQUENCY: Quarterly RESPONSIBLE: Director of Cardiology/Medical Imaging | |

| | | | | | | | |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 03/30/2016 | |
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 | | | |
| (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>visitors.</p> <p>Based on document review, observation and interview, the facility failed to provide a safe and healthful environment in two instances in the Emergency Department (ED) regarding cleaning of I-stat machines and the Emergency Medical Technicians (EMT) room, Room 1341 and one instance of failing to follow isolation procedures related to lack of initiation of contact precautions for patient with identified infection for Medical Surgical/Oncology.</p> <p>Findings:</p> <p>1. Policy Environmental Services, # Section III-F, last reviewed 6/2012 indicates:</p> <p>1. Environmental Services will have a written schedule for cleaning and removal of contaminates in order to maintain the hospital in a clean and sanitary condition.</p> <p>D. All equipment and surfaces are cleaned and decontaminated after contact with blood or OPIM (other potentially infectious material): after the completion of medical procedures, immediately (or as soon as feasible) when surfaces are overtly contaminated, after any spill of blood or infectious materials, at the end of the work shift if the surfaces have been contaminated</p> | S 0554 | <p>The I-Stat Machine should be cleaned and disinfected after every use or daily if not in use. The policy was posted as a read and sign for all Emergency Department Team Members to serve as re-education on this process. The policy is attached.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: 100% Compliance</p> <p>MONITOR: 100% of Machines</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Manager of Emergency Services</p> <p>Tag # S554 - Attachment 1, pages 1-2</p> <p>Room 1341 was cleaned on day of survey. This room is not being at this time. The room will monitored daily and routinely cleaned by Environmental Services. The Cleaning Schedule is attached.</p> <p>DATE CORRECTED: 3-31-16</p> <p>GOAL: 100% Compliance</p> <p>MONITOR: Cleanliness of room</p> | 06/01/2016 | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>during the shift.</p> <p>2. While touring the Emergency Department on 3/30/2016 at 1030 hours, the following conditions were noted:</p> <p>a. I-stat machines (hand held blood analyzers) and supplies are kept on a counter behind the nurse station. When the machines were examined, they were sitting in a dusty, dirty area which did not appear to have been cleaned recently.</p> <p>b. The Emergency Medical Technicians (EMT) room, Room 1341, contained a decontamination tent and roller bed. The room is also being used to store forgotten patient belongings; many appeared to be dirty clothes, shoes and other belongings. The floor was dusty and had brownish dirty areas on the floor.</p> <p>3. Staff member #NO9, ED Manager from 1200 hours to 2400 hours, indicated that the I-stat storage area and the EMT room needed attention.</p> <p>4. Policy: (no policy number indicated), Isolation Precautions, revised/reapproved on 04/2015 indicated on page 1:</p> <p>A. (page 1), informs department receiving the patient what isolation precautions are being utilized.</p> <p>B. (page 1), dons appropriate personal protective equipment, as listed on selected isolation sign.</p> | | <p>FREQUENCY: Daily</p> <p>RESPONSIBLE: Director of Environmental Services</p> <p>Tag # S554 - Attachment 2, pages 1-3</p> <p>Contact Precautions not followed: This was corrected immediately and the team member involved was coached on proper Infection Control precautions. Tracer Rounding is being done to ensure compliance. The monitoring form is attached.</p> <p>DATE CORRECTED: 3-31-16</p> <p>GOAL: 100% compliance</p> <p>MONITOR: 10 Observations per month</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Infection Control and Prevention Manager</p> <p>Tag # S554 - Attachment 3</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>5. Review of Clark Memorial Hospital Isolation Guide (attachment to Policy: Isolation Precautions) indicated on page 1:</p> <p>A. (page 1), table: MRSA (methicillin-resistant staphylococcus aureus) suspected, always isolate, isolation precautions- contact: continue contact precautions until final results available and the organism is not an MDRO (multidrug resistant organisms).</p> <p>6. Review of patient S5 medical record on 3/28/16 at approximately 1530 hours indicated:</p> <p>A. (page 2, history and physical (H&P) lab culture for abdominal wound positive for staphylococcus aureus with sensitivity still pending.</p> <p>B. lab report dated 3/24/16 at 22:30 hours indicated culture body fluid preliminary results for staphylococcus aureus for abdominal wound.</p> <p>C. nursing flow sheets dated 3/24/16 to 3/30/16 lacked documentation of initiation of contact isolation precautions.</p> <p>7. While on tour of facility on 3/28/16 at approximately 1545 hours, in the presence of staff N21 (Director of Medical Surgical) and staff N23 (Registered Nurse [RN] Manager Medical Surgical Oncology), patient S5's room was observed to lack signs</p> | | | |

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 03/30/2016 | |
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 | | | |
| (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 | | | |
| S 0604 Bldg. 00 | <p>identifying isolation contact precautions.</p> <p>8. Staff N21 and staff N23 were interviewed on 3/28/16 at approximately 1545 hours and confirmed contact precautions had not been initiated.</p> <p>9. Staff N17 (Infection Preventionist) was interviewed on 3/29/16 at approximately 1430 hours and confirmed isolation precautions were not observed for patient S5 and confirmed all staff are to follow facility policy and procedure for isolation precautions.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vii)</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> | | | | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>(vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases.</p> <p>Based on document review and staff interview, the hospital failed to monitor the immune status of four of five kitchen health care workers for diseases transmissible through food.</p> <p>Findings:</p> <p>1. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of forborne disease transmission, including the date</p> | S 0604 | <p>Food and Nutrition Declination Form was put in place on 4/4/16 as part of the new-hire process for all team members working in the Food and Nutrition Department. Going forward, completed forms will be on file in the Employee Health Office prior to the team member working in the department. Forms obtained from all current staff as of 4/29/16. Form attached.</p> <p>DATE CORRECTED: 4-29-16</p> <p>GOAL: 100%</p> <p>MONITOR: Forms complete on all new team members</p> <p>FREQUENCY: Monthly</p> <p>RESPONSIBLE: Director of Human Resources</p> <p>Tag S604 - Attachment 1</p> | 04/29/2016 |
|--|--|--------|---|------------|

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--------------------|---|--|--|--|
| S 1118 Bldg. 00 | <p>of onset of jaundice or of an illness specified under subdivision (3), of the food employee or applicant:</p> <p>(1) is diagnosed with an illness due to:</p> <p>(A) Salmonella spp.;</p> <p>(B) Shigella spp.;</p> <p>(C) Shiga toxin-producing Escherichia Coli;</p> <p>(D) Hepatitis A virus; or</p> <p>(E) Norovirus "</p> <p>2. Four kitchen personnel (#s 6 through 9) files lacked documentation to indicate that the above-listed history of the five food transmissible diseases had been obtained.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a</p> | | | |
|--------------------|---|--|--|--|

| | | | | | | | |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 03/30/2016 | |
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 | | | |
| (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>hazard to patients, public, or employees.</p> <p>Based on document review, observation and interview, the facility failed to ensure the safety of adult psychiatric patients on the Behavioral Health Units regarding potentially harmful items in 3 of 4 areas.</p> <p>Findings:</p> <p>1. Hospital Policy: Safety Precautions, Behavioral Health, (no #) last reviewed 01/2015, indicated:</p> <p>POLICY STATEMENT: Safety precautions are initiated for any patient who demonstrates behavior indicating a potential for self harm, aggression toward others, sexual acting out, or any other behavior that may require swift therapeutic intervention.</p> <p>3. Removes any potentially harmful items from the patient's room, i.e., medications, sharp items and any other item that may be used for harm to self or others.</p> <p>During a tour of the Behavioral Health Units (Gero-psych unit on the second floor and the Adult Psych unit on the third floor) on 3/30/2016 at 1330 hours, accompanied by staff members #NO3 and NO4, the following potentially dangerous conditions were noted:</p> | S 1118 | <p>Bed in Seclusion Room: The bed was removed from the seclusion room on the day of survey. The room no longer has a hospital bed. DATE CORRECTED: 3-31-16 GOAL: 100% Compliance MONITOR: No hospital bed in seclusion room FREQUENCY: Daily RESPONSIBLE: Director of Behavioral Health</p> <p>Hospital Bed with electrical cord in room 3613: Zip ties were applied to all hospital beds on the Behavioral Health Units. The zip ties were placed in multiple points to secure the power cords to the frame of the bed. The cord length from the last zip tie to the electrical outlet is 18 inches or less per industry standard. The zip ties are very strong plastic and cannot easily be removed. DATE CORRECTED: 4-15-16 GOAL: 100% Compliance MONITOR: Daily as staff rounds on patients FREQUENCY: Daily and ongoing RESPONSIBLE: Director of Behavioral Health</p> <p>Fire Hose cover: The plastic was replaced with shatter proof glass. This was added to the preventative maintenance schedule for inspection. Non-medical equipment is tested annually. DATE CORRECTED: 4-15-16 GOAL: 100% Compliance MONITOR: Conduct</p> | 04/15/2016 | | | |

| | | | | | | | |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 03/30/2016 | |
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 | | | |
| (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 | | | |
| S 1164 Bldg. 00 | <p>1. The seclusion room on the Gero-psych unit contained an electric hospital bed with an electrical cord attached.</p> <p>2. Room 3613 on the adult unit contained an electric hospital bed with an electrical cord attached.</p> <p>3. The cover on the fire hose on the adult unit was made of plastic and was loosely placed in the door and could easily be broken and have sharp edges.</p> <p>Staff member #NO4 indicated that there had been an internal risk management assessment done and some of what was found by risk management had been done, but there was still a lot to do. Staff member #NO4 indicated that this is an old building and many of the needed changes are expensive.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient</p> | | PM FREQUENCY: Annually RESPONSIBLE: Director of Plant Operations | | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation, document review and interview, the hospital failed to provide evidence of preventive maintenance on 4 pieces of equipment (hepafilter, x-ray chair/Franklin chair, biopsy steps, floor scrubber).</p> <p>Findings:</p> <ol style="list-style-type: none"> On 3/29/16 between 11:30 and 12:15 during facility, in the presence of A10, chief nursing officer, and A16, Facilities Manager, the following was observed: <ol style="list-style-type: none"> At 11:15am, outside the pharmacy, was an electric portable type hepafilter. At 11:40am, in the x-ray room was a chair with a black plastic leather type covering on the arms that was torn and shredding. At 12:15pm, in the stereotactic biopsy room was a small set of steps. Review of 2015 to present facility preventive maintenance (PM) documents lacked documentation of PM for the above equipment or for any floor scrubber. | S 1164 | <p>HEPA Filters: The hospital separated the equipment and designated use for patient care from equipment used by Engineering Services. The policy was updated to reflect the changes. All HEPA Filters were added to the preventative maintenance schedule for inspection. Units used in patient care areas are tested twice a year. Units used by Engineering Services are tested once per year. Additionally, the HEPA filters used in patient care areas will be cleaned by Sterile Supply in between uses.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: PMs provided on HEPA Filters</p> <p>MONITOR: Conduct PM</p> <p>FREQUENCY: Patient care: Two times each year / Non-Patient Care: Annually</p> <p>RESPONSIBLE: Patient Care: Director of Surgical Services / Non-Patient Care: Director of Plant Operations</p> | 06/01/2016 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>3. On 3/30/16 at 3:55pm, A16 indicated the facility did use floor scrubbers, but did not have documentation of PM for any floor scrubber.</p> <p>4. On 3/30/16 at 4:00pm, A10 indicated the facility did not have a policy or written procedure for PM of equipment and did not have evidence of PM for the hepafilter, the "Franklin" chair or the steps.</p> | | <p>The Floor Scrubber was tested and there were no issues. It was added for testing under the preventative maintenance plan. Non-medical equipment is tested annually.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: Floor Scrubber in good working order</p> <p>MONITOR: Conduct PM</p> <p>FREQUENCY: Annually</p> <p>RESPONSIBLE: Director of Plant Operations</p> <p>X-Ray room Franklin chair: The covering was removed and chair cleaned was on 5/15/15. The Chair was added for testing under the preventative maintenance plan. Non-medical equipment is tested annually.</p> <p>DATE CORRECTED: 5-15-16</p> <p>GOAL: Chair to be clean without tears or shredding</p> <p>MONITOR: Conduct PM</p> <p>FREQUENCY: Annually</p> <p>RESPONSIBLE: Director of Plant Operations</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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 |
|--------------------|--|---------------|--|----------------------|
| S 1172 Bldg. 00 | <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with 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</p> | | <p>Steps in Stereotactic Biopsy room: The steps were tested and there were no issues. They were added added for testing under the preventative maintenance plan. Non-medical equipment is tested annually.</p> <p>DATE CORRECTED: 6-1-16</p> <p>GOAL: Steps in good working order</p> <p>MONITOR: Conduct PM</p> <p>FREQUENCY: Annually</p> <p>RESPONSIBLE: Director of Plant Operations</p> | |

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 03/30/2016 | |
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 | | | |
| (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>(C) Safe practice.</p> <p>Based on document review, observation and interview, the hospital failed to maintain a clean and orderly building in 5 areas (biomedical engineering, room 6005, room 3507, pharmacy anteroom and bulk supply storage refrigerator).</p> <p>Findings:</p> <p>1. Review of the Environmental Services Policy #: Section III-F indicated the Environmental Services Department Will have a written schedule for cleaning and removal of contaminates in order to maintain the hospital in a clean and sanitary condition. The policy was last reviewed 6/2012.</p> <p>2. Review of Policy: S-017.0, titled Refrigerators, Freezers, Microwaves; indicated the following: All Departments: Cleaning will consist of exterior and interior.</p> <p>3. On 3/29/16, during tour of the facility, in the presence of A16, Facilities Manager, and A10, Chief Nursing Officer, the following was observed:</p> <p>a. At 10:40am in the biomedical engineering room were cardboard boxes stacked on top of each other in an unorganized manner, sitting in a corner on the floor in an approximate 2' x 3'</p> | S 1172 | <p>The Biomedical Engineering work room: Room was cleaned out and organized the day of the survey. The cardboard boxes were removed and the room was dusted.</p> <p>Room 6005: Generator room was cleaned and organized the day of survey. Clutter was removed and many items sent to long term storage.</p> <p>Room 3507 was cleaned and organized the day of the survey. The cardboard boxes, long pipe and clutter on the floor were removed and the room was dusted. EOC Rounding Template attached.</p> <p>DATE CORRECTED: 3-31-16</p> <p>GOAL: Room to remain clutter free</p> <p>MONITOR: During Environmental Care Rounds</p> <p>FREQUENCY: Quarterly</p> <p>RESPONSIBLE: Director of Plant Operations</p> <p>Tag #S1172 - ATTACHMENT 1</p> <p>Pharmacy chair: The adjustable</p> | 03/31/2016 | | | |

| | | | | | |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 03/30/2016 |
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 | | |
| (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>area, dust buildup was noted on the floor around the boxes.</p> <p>b. At 10:45am Generator room 6005 appeared cluttered and disorderly with 16 pieces of equipment, tabled as "retired", noted to be scattered throughout and 3 cardboard boxes were observed to sitting on the floor.</p> <p>c. At 11:00am in an air handler mechanical room (#3507) cardboard boxes and long pipes were noted to be stored on top of an air duct, a box of long metal pieces were observed to by lying open on the floor and 2 rechargeable lead-acid batteries were sitting on the floor.</p> <p>d. At 11:15am in the pharmacy anteroom the adjustable work chair was observed with heavy dust along the back edge of the seat and on the base.</p> <p>e. At 2:40pm in the bulk supply storage area was a refrigerator. The interior of the refrigerator appeared dirty/dusty.</p> <p>4. On 3/29/16 at 10:40am, A10 indicated cardboard boxes should not be stored/kept directly on the floor. At 10:45am A10 indicated the "retired" equipment should be discarded or at least removed from the generator room and be stored in an orderly fashion. At 11:15am, A10 indicated housekeeping should be cleaning all surfaces in the pharmacy</p> | | <p>chair in the Pharmacy anteroom was cleaned the day of survey.</p> <p>Pharmacy Refrigerator: The pharmacy supply storage refrigerator was cleaned the day of survey. Cleaning schedule attached.</p> <p>DATE CORRECTED: 3-31-16</p> <p>GOAL: Pharmacy to be clean at all times</p> <p>MONITOR: Weekly</p> <p>FREQUENCY: Weekly</p> <p>RESPONSIBLE: Director of Pharmacy</p> <p>Tag S1172 - ATTACHMENT 2</p> | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150009 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/30/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER CLARK MEMORIAL HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MISSOURI AVE JEFFERSONVILLE, IN 47130 |
|---|--|

| (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>anteroom, including the back and base of the chair. At 2:40pm, A10 indicated the staff of the bulk supply area are to keep their refrigerators clean inside and out.</p> <p>5. On 3/29/16 at 11:00am, A16 indicated the boxes and pipes should not be on top of the air duct, the box of metal should not be lying on the floor, nor should the batteries and that the batteries should have been taken to recycling.</p> | | | |