

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/01/2011
NAME OF PROVIDER OR SUPPLIER  METHODIST HOSPITALS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN46402		
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005002</p> <p>Survey Date: 08/29/2011-09/1/2011</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith Laboratorian/Medical Surveyor</p> <p>Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 09/13/11</p>	S0000	Action plans are documented under each deficiency.		

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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S0322	<p>410 IAC 15-1.4-1(c)(6)(H)</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>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on policy and procedure review, document review, observation and staff interview, the chief executive officer failed to ensure all services have policies and procedures that are updated as needed in relation to testing emergency eye wash stations in 2 of 15 (Central Sterilization) areas toured.</p> <p>Findings: 1. Policy No. PO_42, titled "Testing of Eye Wash Stations" reviewed at 3:00 PM on 8/29/11, indicated on pg. 1, under Policy section, "To insure eye wash stations are operating correctly and free of obstructions. This procedure is done at Northlake and Southlake Campuses. Plant Operations will, on a weekly basis, inspect and test the emergency eye wash station located in the boiler room at Northlake and located in the chiller room and kitchen at Southlake..." 2. Review of the manufacturer's tag located on the emergency eye wash station located at</p>	S0322	<p><b>Corrective Actions:</b> 1) Policy MM_52 (Attachment A) outlines the process for inspecting and testing eye wash stations in the Sterile Processing Department at both campuses. A new Eyewash Station Testing log was created (Attachment B).  2) Sterile Processing staff were educated on the weekly testing/inspection requirements defined in policy MM_52 and the new Eyewash Station Testing log to use for documentation (Attachment C: Agenda and Education record).  <i>Responsible Person(s):</i> Chief Supply Chain Officer</p> <p><b>Plan for Preventing Recurrence:</b> 1) Sterile Processing Supervisors at the Northlake and Southlake campuses inspect the Eyewash Station Testing logs to confirm required weekly testing is</p>	09/21/2011	

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	<p>the:</p> <p>A. Northlake campus on 8/29/11 at approximately 1:38 PM, indicated "Test this unit each week." Dates on the tag were documented as 11/10/08, 1/12/09, 1/20/09, 2/2/09, 3/8/09, 4/5/09, 5/7/09, 6/2/09, 7/1/09, 12/7/09, 1/18/10, 11/4/10, 12/9/10, 1/9/11, 2/9/11, and 3/29/11.</p> <p>B. Southlake campus on 8/31/11 at approximately 12:45 PM, indicated "Inspect this unit carefully before signing inspection record." It did not specify weekly, but policy does. Dates on the tag were documented as 3 dates illegible, 3/30/11, 4/28/11, 5/19/11, 6/8/11, 7/16/11, 8/10/11, and 8/31/11.</p> <p>3. While on tour of the:</p> <p>A. Northlake Campus on 8/29/11 at approximately 1:38 PM, in the company of personnel P3, P15 and P17, the following was observed in the Central Sterilization Department instrument cleaning area:</p> <p>a. an emergency eye wash testing station that had not been tested according to manufacturer's recommendation of weekly.</p> <p>B. Southlake Campus on 8/31/11 at approximately 12:45 PM, in the company of personnel P3, P15 and P2, the following was observed in the Central Sterilization Department instrument cleaning area:</p> <p>a. an emergency eye wash testing station that had not been tested according to manufacturer's recommendation of weekly.</p> <p>4. Personnel P17 was interviewed on 8/29/11 at approximately 1:50 PM and P2 on 8/31/11 at approximately 1:00 PM, and confirmed the</p>		<p>documented.</p> <p>2) In the case of missing documentation, responsible staff are immediately notified and are reminded of the documentation requirements.</p> <p>3) Staff who do not improve compliance receive corrective action.</p> <p>4) Goal is 100%.</p> <p>5) Compliance to date is 100%.</p> <p><i>Responsible Person(s):</i> Sterile Processing Supervisors at Northlake and Southlake campuses</p>		

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	above-mentioned emergency eye wash stations were not tested weekly according to manufacturer's recommendation. And policy no. PO_42, titled "Testing of Eye Wash Stations" was not updated to include testing of the emergency eye wash stations in the Central Sterilization Department instrument cleaning areas for both campuses.				

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S0362	<p>410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors.</p> <p>(B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement.</p> <p>(C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor.</p> <p>(D) Use discretion and sensitivity in contacts with potential organ donor families.</p> <p>(E) Notify the appropriate procurement organization of potential organ donors.</p> <p>(F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review, the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths.</p> <p>Findings:</p>	S0362	<p><b>Corrective Actions:</b></p> <p>1) Upon further medical record review, it was identified that the patient with the missed referral in December 2010 (MR#1001209186) did not die at Methodist Hospital. (Attachment D: 4 th Quarter Gift of Hope</p>	09/20/2011	

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S1118	<p>1. Review of the contract between the hospital and the Gift of Hope Organ &amp; Tissue Donor Network indicated the hospital shall provide "All notification of death or imminent death...".</p> <p>2. Review of the Donation Activity Report for the 4th Quarter 2010 indicated 31 deaths occurred in December 2010 and only 30 deaths were reported.</p> <p>3. Interview with Employee A2 and Employee A4 on August 31, 2011 at 1:30pm verified 31 deaths occurred in December 2010 and only 30 deaths were reported.</p> <p>410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation and staff interview, the facility failed to ensure that no condition exists which could be</p>	S1118	<p>Donation Report)</p> <p>2) According to the medical record, the patient was discharged on 12/8/2010 at 2:00 p.m. (Attachment E).</p> <p>3) The patient was discharged to Lincolnshire Health and Rehab located in Merrillville, Indiana.</p> <p>4) Lincolnshire Health and Rehab confirmed that the patient died on 12/26/10 at 7:12 a.m. (Attachment F).</p> <p>5) Therefore, no action was taken. Methodist reported all deaths to the Gift of Hope as required.</p> <p><b>Corrective Actions:</b> 1) Policy MM_52 (Attachment A) outlines the process for</p>	09/21/2011	

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	<p>hazardous to employees related to testing of emergency eye wash stations in 2 of 15 (Central Sterilization) areas toured.</p> <p>Findings:</p> <p>1. Review of the manufacturer's tag located on the emergency eye wash station located at the:</p> <p>A. Northlake campus on 8/29/11 at approximately 1:38 PM, indicated "Test this unit each week." Dates on the tag were documented as 11/10/08, 1/12/09, 1/20/09, 2/2/09, 3/8/09, 4/5/09, 5/7/09, 6/2/09, 7/1/09, 12/7/09, 1/18/10, 11/4/10, 12/9/10, 1/9/11, 2/9/11, and 3/29/11.</p> <p>B. Southlake campus on 8/31/11 at approximately 12:45 PM, indicated "Inspect this unit carefully before signing inspection record." It did not specify weekly, but policy does. Dates on the tag were documented as 3 dates illegible, 3/30/11, 4/28/11, 5/19/11, 6/8/11, 7/16/11, 8/10/11, and 8/31/11.</p> <p>2. While on tour of the:</p> <p>A. Northlake Campus on 8/29/11 at approximately 1:38 PM, in the company of personnel P3, P15 and P17, the following was observed in the Central Sterilization Department instrument cleaning area:</p> <p>a. an emergency eye wash testing station that had not been tested according to manufacturer's recommendation of weekly.</p> <p>B. Southlake Campus on 8/31/11 at approximately 12:45 PM, in the company of personnel P3, P15 and P2, the following was observed in the Central Sterilization Department instrument cleaning area:</p>		<p>inspecting and testing eye wash stations in the Sterile Processing Department at both campuses. A new Eyewash Station Testing log was created (Attachment B).</p> <p>2) Sterile Processing staff were educated on the weekly testing/inspection requirements defined in policy MM_52 and the new Eyewash Station Testing log to use for documentation (Attachment C: Agenda and Education record).</p> <p><i>Responsible Person(s):</i> Chief Supply Chain Officer</p> <p><b>Plan for Preventing Recurrence:</b></p> <p>1) Sterile Processing Supervisors at the Northlake and Southlake campuses inspect the Eyewash Station Testing logs to confirm required weekly testing is documented.</p> <p>2) In the case of missing documentation, responsible staff are immediately notified and are reminded of the documentation requirements.</p> <p>3) Staff who do not improve compliance receive corrective action.</p> <p>4) Goal is 100%.</p> <p>5) Compliance to date is 100%.</p> <p><i>Responsible Person(s):</i> Sterile Processing Supervisors at Northlake and Southlake campuses</p>				

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	<p>a. an emergency eye wash testing station that had not been tested according to manufacturer's recommendation of weekly.</p> <p>3. Personnel P17 was interviewed on 8/29/11 at approximately 1:50 PM and P2 on 8/31/11 at approximately 1:00 PM, and confirmed the above-mentioned emergency eye wash stations were not tested weekly according to manufacturer's recommendation.</p>				