

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151330	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/29/2013
NAME OF PROVIDER OR SUPPLIER ADAMS MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 MERCER AVE DECATUR, IN 46733		
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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 004747</p> <p>Survey Date: 5-28-13 to 5-29-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Steve Poore, BS MLT Medical Surveyor 3</p> <p>QA: claughlin 06/13/13</p>	S000000	All citations were addressed by the facility by date of plan of correct submission, June 26, 2013.		

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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S000178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and interview, the facility failed to post a copy of its current license in a conspicuous area open to patients and public for 1 of 2 facility locations operated under the hospital license.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a tour on 5-28-13 at 1215 hours, no State license was observed in the main entrance reception and waiting area of the facility. 2. During an interview on 5-28-13 at 1215 hours, staff A3 confirmed the hospital license was not on display in the main entrance area or other public area elsewhere in the building. 	S000178	<p>S 178</p> <p>On 5-28-13 the Hospital's State Operating License was displayed in the reception area of Administration. During the survey, the survey indicated that this was not a conspicuous area open to the public. As of 5-28-13, a copy of Adams Memorial Hospital's operating license posted in a conspicuous area open to patient and the public in the following locations. A picture of each location entrance and a picture of the license location are including as attachments to this report. Adams Memorial Hospital has the following three public entrances all of which have a copy of the license posted. Main Entrance—attachment 1A-D Rehab Entrance—attachment 2A-B Emergency Department Entrance—attachment 3A-B Each year a new license will be placed in each of these locations. Maureen Miller, Quality & Risk Manager and Compliance Officer</p>	05/31/2013	

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			is responsible for this correction.	

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S000330	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on manufacturer's package insert review, personnel file review, and staff interview, the governing board failed to ensure that TB (tuberculosis) testing was performed per the manufacturer's recommendations for 3 of 4 staff hired in 2012 and 2013 (staff members N1, N2 and N3).</p> <p>Findings: 1. at 4:25 PM on 5/29/13, review of the package insert for the Aplisol (Tuberculin Purified Protein Derivative) solution used for TB testing indicated: a. in the area "Interpretation of Tuberculin Reaction", it reads: "Readings</p>	S000330	<p>S 330 Based upon recommendation made by the ISDH surveyors, on 5-30-13, Occupational Health initiated updating the "CMS Physical Exam Form—AHN Employee" to include the time read. All old forms were discarded as of this date.</p> <p>On 6-17-13, Policy 630.156.003 "Tuberculin (Mantoux) Skin Test" (TST) was updated to state that both date and time administered AND read must be included on original documentation. If this information is absent the test is considered invalid and must be re-administered. An email was</p>	06/17/2013	

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	<p>of Mantoux reactions should be made...during the period from 48 to 72 hours after the injection..."</p> <p>2. at 2:45 PM on 5/29/13, review of personnel files indicated:</p> <p>a. staff member N1 was a RN (registered nurse) hired 8/10/12 who had a TB test given on 8/7/12 and read on 8/10/12 that lacked a time given and time read that would indicate the test was read within 48 and 72 hours, as recommended by the manufacturer of the solution</p> <p>b. staff member N2 was a RN hired 1/17/13 who had a TB test given on 1/15/13 and read on 1/17/13 that lacked a time given and time read that would indicate the test was read within 48 and 72 hours, as recommended by the manufacturer of the solution</p> <p>c. staff member N3 was a nursing assistant hired 12/12/12 who had a TB test given on 12/4/12 and read on 12/7/12 that lacked a time given and time read that would indicate the test was read within 48 and 72 hours, as recommended by the manufacturer of the solution</p> <p>3. interview with staff member #53, the chief nursing officer, at 4:25 PM on 5/29/13 indicated:</p> <p>a. it cannot be determined that TB tests were read within 48 and 72 hours if staff giving the injections and reading the</p>		<p>sent to corporate medical staff explaining the changes to the form.</p> <p>Education was provided to staff by CMS manager on 6/17, copies of the policy, and email were provided to all employees that arecertified to read/administer TST. A signoff sheet was used to signify that staff had read and are responsible for knowing and practicing the information provided.</p> <p>Monitoring will be completed daily by the Occupational Health/Infection Prevention Nurse. Any TST that lacks the proper documentation (date/time administered AND read) will be considered invalid and must be repeated.</p> <p>Attachments—4A-E</p>				

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	injections fail to document the time the tests were given and the time the tests were read				

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S000394	<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 interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 21 contracted services.</p> <p>Findings:</p> <p>1. On 5-28-13 at 1550 hours, a list of all contracted services titled ' Annual Review of Contracted Services - 2013 ' was received from staff A7. The list of services lacked a description of the service provided by each provider and failed to indicate a service provider for anesthesia machines, biohazardous waste, elevators, endoscope service, exhaust hood certification, 3 fire services, 2 generator services, laundry service, medical reprocessor, medical physicists, pest control, 6 radiology equipment services, and sterilizers.</p>	S000394	<p>S 394</p> <p>On June 24, 2013, Adams Memorial Hospital developed a listof contracted services which includes the following suggested contractors: Anesthesia Machines Biohazardous Waste Elevators Endoscope Service Exhaust Hood Certification Fire Services Generator Services Laundry Services *Medical Reprocessor-our radiology department is completely digital andwe do not use films, therefore no contract is needed Medical Physicists Pest Control Radiology Equipment Sterilizers</p> <p>The attached list contains the name of the contracted service and abrief description of the scope of service provided by the</p>	06/24/2013	

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	<p>2. Review of facility documentation indicated the following: anesthesia machine service by CS1, biohazardous waste disposal by CS2, elevator service by CS3, endoscope service by CS4, exhaust hood inspection by CS5, fire service providers included CS6 and CS7 and fire panel monitoring by CS8, generator service by CS9 and CS10, laundry services by CS11, medical reprocessing by CS12, medical physicist calibration and inspection by CS13, pest control by CS14, radiology equipment service by CS15, CS16, CS17, CS18, CS19 and CS20, and sterilizer service by CS21.</p> <p>3. On 5-29-13 at 1440 hours, staff A3 confirmed the list of contracted services failed to include the indicated service providers and lacked a description of the services provided by each provider.</p>		<p>contractor.</p> <p>Quality & Risk Manager, Compliance Officer will be responsible formaintaining the list of contracted services on an as needed basis as contracted services are added and deleted.</p> <p>Attachment 5A</p>		

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to ensure that all services were evaluated through the Quality Assessment Performance Improvement (QAPI) program for 21 contracted services.</p> <p>Findings:</p> <p>1. The facility QAPI Program 2013 (approved 4-13) lacked a provision for monitoring, evaluating, and reporting contracted services provided at the facility.</p> <p>2. Review of QAPI program documentation failed to indicate monitoring and periodic reporting for the following: anesthesia machine service, biohazardous waste, elevator service,</p>	S000406	<p>S 406 On June 24, 2013 Adams Memorial Hospital developed the following indicators to monitor, evaluate and review the services provided by the following contracted services as part of the hospital's QAPI program. Anesthesia Machines Biohazardous Waste Elevators Endoscope Service Exhaust Hood Certification Fire Services Generator Services Laundry Services *Medical Reprocessor-our radiology department is completely digital and we do not use films, therefore no contract is needed Medical Physicists Pest Control Radiology Equipment Sterilizers</p>	06/24/2013			

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	<p>endoscope service, exhaust hood certification, 3 fire service providers, 2 generator services, laundry service, medical single use device reprocessor, medical physicists, pest control, 6 radiology equipment service providers, and a sterilizer service.</p> <p>3. During an interview on 5-29-13 at 1430 hours, staff A7 confirmed that the QAPI program failed to monitor, evaluate and review the indicated services.</p>		<p>The attached list contains the name of the contracted service and abrief description of the scope of service provided by the contractor.</p> <p>Quality & Risk Manager, Compliance Officer will be responsible for reviewing the indicators on a quarterly basis as part of the QAPI program.</p> <p>Attachment 6A-S</p>		

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S000422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be</p>				

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	<p>identified by a hospital that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p>			

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	<p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2) Based on document review and interview, the facility failed to have a policy/procedure for reporting to the Indiana State Department of Health (ISDH) each reportable event determined by the quality assessment and improvement program to have occurred within the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Incident/Accident Reporting (reviewed 1-13) failed to indicate a process for reporting each reportable event per 410 IAC 15-1.4-2.2(a)(2). During an interview on 5-29-13 at 1600 hours, staff A5 confirmed that the policy/procedure failed to indicate the process for reporting an event to ISDH to ensure that events were reported in accordance with State requirements. 	S000422	<p>S 422 The hospital Incident/Accident Policy was revised on 6/17/2013 to include the identified 28 reportable events considered by the ISDH as of January 1, 2009 through present. In addition, the policy was also revised to include the process to follow when reporting an incident, including acceptable time frames, information to include and not to include in the report and how a report may be identified. The policy was presented to Quality Council on 6/19/13 and the Board of Trustees on June 6/26/13. Quality & Risk Manager, Compliance Officer is responsible for maintaining this policy on an annual basis. Attachment—7A-B</p>	06/26/2013	

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation and interview, the infection control committee failed to ensure the separation between the decontamination area and the clean reprocessing area of the central processing unit, related to the pass through window.</p> <p>Findings: 1. while on tour of the central sterile/reprocessing unit at 11:10 AM on 5/29/13 in the company of staff members #53, the chief nursing officer, and #56, the surgery manager, it was observed that the pass through window was open with no staff about in either the decontamination room, or the sterile area/room</p>	S000596	<p>S 596 Based upon recommendation made by the ISDH surveyors, on 6-11-13, education was provided to surgery manager regarding the importance of maintaining separation between the clean reprocessing area and the decontamination room. Employee was provided with a copy of policy 701.016.001 "Central Sterilization Services(CS), Environmental Control, Infection Control, and Safety Policies" for review. Education was provided to all surgery staff members at the June 11 th staff meeting. Policy 701.016.001 was reviewed and discussed. An attendance sheet was used to signify that staff has reviewed the policy and are responsible for knowing and</p>	06/11/2013			

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	<p>2. interview with staff member #56, the surgery manager, at 11:15 AM on 5/29/13 indicated:</p> <p>a. it was unknown, by this staff member, that the pass through window needed to be closed, except when instruments were being passed through</p> <p>3. interview with staff member #55, a surgical technician, at 11:20 AM on 5/29/13, indicated:</p> <p>a. it was known by this staff member that the pass through window did need to be kept closed when not passing instruments through to the clean side to decrease possible cross contamination from the dirty side to the clean side</p> <p>b. the pass through window was opened that AM to pass ortho instruments through and staff had failed to close the window after the process of passing through had been completed</p>		<p>practicing the information provided.</p> <p>CNO is responsible for ensuring all surgery staff are educated regarding this policy.</p> <p>Attachments—8F-H</p>	

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S000598	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage. Based on policy and procedure review, observation, and interview, the infection control committee failed to implement its policy related to surgical masks.</p> <p>Findings: 1. at 9:15 AM on 5/29/13, review of the policy and procedure "Operating Room Attire - Personnel", with a policy number of 701.002.002, and a most recent date reviewed of 4/2013, indicated: a. under "Procedure", it reads: "A. Appropriate surgical attire...h. Masks are considered PPE (personal protective equipment) and should be removed when leaving the semi restricted area or the surgical suite..."</p> <p>2. while on tour of the pre operative area</p>	S000598	<p>S 598 Based upon recommendation made by the ISDHsurveyors, on 6-11-13, Remedial education was provided to the nurse anesthetist and Zimmer representative, including review of policy 701.002.002 "Operating Room Attire – Personnel." In addition, education was provided to all surgery staff members at the June 11 th staff meeting. Policy 701.002.002 was reviewed and discussed. An attendancesheet was used to signify that staff has reviewed the policy and are responsible for knowing and practicing the information provided.</p> <p>Patient Care Manager of Surgery is responsible for the education of</p>	06/11/2013			

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	<p>of the surgery department in the company of staff member #56, the surgical manager, at 10:40 AM on 5/29/13, it was observed that:</p> <p>a. the nurse anesthetist was in the nurses' station area with their surgical mask untied and dangling about the neck</p> <p>3. while on tour of the post operative area of the surgery department in the company of staff member #56, the surgical manager, at 10:45 AM on 5/29/13, it was observed that:</p> <p>a. the Zimmer representative was in the hallway of the surgery area with their surgical mask untied and dangling about the neck</p> <p>4. interview with staff member #56, the surgical manager, at 10:40 AM and 10:45 AM on 5/29/13, indicated:</p> <p>a. staff are to remove their surgical masks when leaving the surgical suite</p> <p>b. the personnel observed with masks down about the neck in the surgery area should have removed their masks upon exiting the surgery suite</p>		<p>staff and enforcement and monitoring of this policy on an asneeded basis.</p> <p>Attachment—9H, I, J</p>		

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S000610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on review of policy/procedure and staff interview, the facility failed to provide a food preparation and storage program that follows the rules of the ISDH Retail Food Establishment Sanitation Requirements, 410 IAC 7-24, for one of one food service areas surveyed.</p> <p>Findings include:</p>	S000610	S 610 Adams Memorial Hospital has been using just temps as the safe guard for potentially hazardous foods since inspection by the ISDH. The attached log sheets indicate the dates, time and frequency of the monitoring that has been put into place. The Policy: Displaying or holding potentially hazardous foods (#801.166.001) was suspended	05/30/2013

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	<p>1). On 05/29/13 between 9:00 am and 9:30 am, review of policy titled:</p> <p>"POLICY: DISPLAYING OR HOLDING POTENTIALLY HAZARDOUS FOOD</p> <p style="text-align: center;">ADAMS MEMORIAL HOSPITAL DECATUR, INDIANA</p> <p>POLICY #: 801.166.001 ISSUED BY: NUTRITIONAL SERVICES DATE ISSUED: 03/23/01 DATE REVISED: 03/23/04 ANNUAL REVIEW DATE: 04/09, 08/11, 01/12, 01/13 SUPERSEDES: 801.166.000 PAGE (1) OF (1) ISSUED TO: NUTRITIONAL SERVICES"...states in the section, "PROCEDURE:...B.", " During serving periods, which are less than four hours per meal, time is used as a temperature control..."</p> <p>2). In interviews on 05/29/13, the following information was obtained:</p> <p>a). On 05/29/13 between 9:00 am and 9:30 am, staff member SP1, confirmed time was being used as a temperature</p>		<p>during survey on 5/29/13. Thedietary department had the policy: Monitoring Food Temperatures (801.156.002)as a policy in the department since 1991, see attached. The only time this policy was not beingfollowed was during serving periods, which were less than four hours. Once this issue was brought to the Dietary'sattention, this policy was continued during serving periods as well. Attachment 10A-B</p> <p>In addition, we have also been in contact with Albert Daegerof the SBOH and have been working to receive a waiver from the state for theuse of this policy, "Time as a Public Health Control " which has been newlywritten with his help and now we are waiting to hear back that its ok to usePolicy (#801.170.00 Time as a Public health control). We have been in contactby email with Mr. Daeger on the following dates in the writing and approvalprocess 6-13-13, 6-14-13, 6-14-13, and 6-19-13 and believe as of this last dateall has been met and approval is forth coming. See attached.</p> <p>Attachment 10C Food Service Manager is responsible for continued monitoringof food temperatures until such time as the facility has been granted therequested waiver.</p>				

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	control and had not been approved by ISDH (Indiana State Department of Health). b). On 05/29/13 at 9:05 am, staff member SP11 (ISDH employee), confirmed the facility had not been approved to operate as "time" being used as a temperature control.				

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S001114	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(1)</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>(1) No condition in the facility or on the grounds shall be maintained which may be conducive to the harborage or breeding of insects, rodents, or other vermin.</p> <p>Based on observation and interview, the facility failed to maintain its environment and prevent the harborage of rodents or other vermin at the hospital.</p> <p>Findings:</p> <p>1. During a tour of the dietary dry storage room on 5-28-13 at 1220 hours, the following condition was observed: a rodent monitor container dated 12-29-09 containing a disarmed mousetrap with evidence of suspected black animal waste was noted under a standing wire rack containing dried food products.</p> <p>2. During an interview on 5-28-13 at 1220 hours, staff A3 confirmed that the pest control service had not maintained the rodent monitor and confirmed that evidence of rodent activity was present in</p>	S001114	<p>S 1114 Pest Control, outdated rodent trap, during the hospital physical plant tour it was noted that a rodent trap in the dry storage area was out of date, along with an insect trap in the same room that was within date.</p> <p>On 6/14/13 Nick Nelson, Director of Support Services, contacted Rose Pest Control and advised them of the above issues. Rose stated that the rodent trap was placed before they had begun to barcode complete rooms for the number of traps and therefore must have been missed, or not dated properly.</p> <p>The hospital advised Rose that the trap had been removed since we currently do not have any rodent issues, didn't think we would need another trap at this time.</p> <p>Rose stated that barcoding the rooms should preclude the issue</p>	06/14/2013			

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	the monitor container.		from happening in the future. In addition, Rose has been added to the list of contracts and QAPI program to monitor, evaluate and review. Director of Support Services will be responsible for ensuring all traps have been accounted for during each inspection and Quality & Risk Manager, Compliance Officer will be responsible for ensuring the contracted service has been evaluated and monitored appropriately.		

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on policy and procedure review, document review, observation, and interview, the facility failed to ensure that no condition would be created that might result in a hazard to patients or employees in four areas toured: ED (emergency department), OB (obstetrics department), ICU (intensive care unit), and Med/Surg (the medical/surgical nursing unit).</p> <p>Findings:</p> <p>1. at 3:40 PM on 5/29/13, review of the policy and procedure "Cleaning and Sanitizing Nursing Pantry Refrigerators", policy number 801.414.000, with a most recent revised date of 01/13, indicated:</p> <p>a. in the "Policy Statement" area: "Cleaning and sanitizing is done as needed."</p> <p>b. in the "Purpose" area: "In compliance with our safe food handling practices, optimum cleaning and</p>	S001118	S 1118 #1-6 Policy # 801.414.001 was clarified and the most current policy was placed in the policy book located in the Dietary department. In addition, the policy will be reviewed with staff on 6-24-13, with emphasis on the highlighted area of the policy submitted. Food Service Manager is responsible for monitoring this policy as needed. Attachment 11A #7 & #8 The existing OB policy inference to the frequency of checking for expiration date on stocked supplies on the unit was converted into a general nursing policy that addresses unit/equipment maintenance for all departments. Education was/will be provided to staff by their managers: On June 11th and 13th in Surgery and ambulatory On June 12th and 13th in ICU and Med/Surg On June 20th education provided in ER On June 20th education provided in OB Each Patient Care	06/24/2013			

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	<p>sanitizing of the nursing pantry refrigerators will be assured."</p> <p>2. at 3:45 PM on 5/29/13, review of the document "Clean Up List", indicated:</p> <p>a. this check off list had documentation by staff in the area that indicated "Floor pantries" were cleaned on May 6th and May 20th</p> <p>3. while on tour of the ICU at 1:55 PM on 5/28/13, in the company of staff members #53, the chief nursing officer, and #52, the ICU manager, it was observed that the pantry refrigerator (for patient food items) was dirty with food crumbs and debris on the main unit shelves and door shelves</p> <p>4. while on tour of the OB unit at 3:05 PM on 5/28/13, in the company of staff members #53, the chief nursing officer, and #57, the OB nursing manager, it was observed that the pantry refrigerator (for patient food items) was dirty with food crumbs and debris on the main unit shelves and door shelves</p> <p>5. while on tour of the Med/Surg nursing unit at 11:40 AM on 5/29/13, in the company of staff members #53, the chief nursing officer, and #54, the Med/Surg nursing manager, it was observed that the pantry refrigerator (for patient food items)</p>		<p>Manager of each nursing unit is responsible for ensuring compliance with this policy on an as needed basis as part of management of the department. Attachment 11B #9 & #10 Warming cabinet – Policy written in regards to warming cabinets that addresses the ECRI recommended maximum temperatures for blanket and fluid warmers. A sign was posted on all warming cabinets indicating the maximum warming cabinet temperatures for blankets and fluids. A warming cabinet temperature log was developed and posted on all warming cabinets. Nursing will monitor and record warming cabinet temperatures daily. Managers in the departments that have warming cabinets will monitor temperature logs routinely for compliance. In addition, a thermometer was installed in the warming cabinet located in ICU and the temperature of the warming cabinet was regulated until the temperature of the cabinet was no greater than the maximum ECRI recommendation. Education was/will be provided to staff by their managers: On June 11 th and 13 th in Surgery and ambulatory On June 12th and 13th in ICU and Med/Surg On June 20 th education provided in ER On June 20 th education provided in OB The</p>		

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	<p>was dirty with food crumbs and debris under the two lower vegetable drawers and in the freezer (lower shelf and the door shelf)</p> <p>6. interview with staff member #58, the director of support services, at 4:25 PM on 5/29/13, indicated:</p> <p>a. there is a policy (provided to surveyor) with the same policy number (801.414.000) and a slightly different title "Cleaning and Sanitizing Nursing Refrigerators" that indicates cleaning and sanitizing of nursing pantry refrigerators is to be done "as needed and on a bi-monthly schedule"</p> <p>b. cleaning is supposed to be done per the "Clean Up List" document, which is bi-monthly</p> <p>c. the nutritional staff member doing the cleaning may need some extra training in what the expectations are related to appropriate "cleaning and sanitizing" per the policy and procedure</p> <p>7. while on tour of the ICU at 2:05 PM on 5/28/13, in the company of staff member #53, the chief nursing officer, it was observed in room #275 that the following supplies and lab tubes were expired:</p> <p>a. one BD (Becton Dickinson) Vacutainer that expired 12/11</p> <p>b. one BD Vacutainer that expired 9/12</p>		<p>policy and temperature logis attached. Each Patient Care Manager of each nursing unit is responsible for ensuring compliance with this policy on an as needed basis as part of management of the department. Attachment 11C-D</p>				

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	<p>c. one light green top blood tube that expired 3/12; one that expired 4/12; and one that expired 3/13</p> <p>d. one dark green top blood tube that expired 6/12; one that expired 7/12; and one that expired 4/13</p> <p>e. one light purple top blood tube that expired 6/12 and one that expired 4/13</p> <p>f. one red top blood tube that expired 2/13</p> <p>g. one light blue top blood tube that expired 10/11</p> <p>8. interview with staff member #53, the chief nursing officer, at 2:00 PM on 5/28/13 and 4:00 PM on 5/29/13 indicated:</p> <p>a. there is no policy and procedure or process related to frequent/routine checking of expiration dates on stocked supplies on the nursing units, (except for one related to the OB unit)</p> <p>b. it is expected that stocks of supplies on the nursing units will be checked routinely for expiration dates to decrease the risk of using expired supplies and, in the case of lab tubes, possibly reporting incorrect lab results to physicians that could create ill effects on patients</p> <p>9. while on tour of the ICU at 2:00 PM on 5/28/13, in the company of staff member #53, the chief nursing officer, it was observed that the Blickman blanket</p>						

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	<p>warmer, in the storage/clean utility room, was extremely hot to touch and was set with the dial between 5 & 6</p> <p>10. while on tour of the ED at 4:00 PM on 5/29/13, in the company of staff member #53, the chief nursing officer, it was observed that the Steris/Amsco blanket warmer (lower cabinet) was reading at 151 degrees</p> <p>11. interview with staff member #53, the chief nursing officer, at 2:00 PM on 5/28/13 and 4:25 PM on 5/29/13, indicated:</p> <ul style="list-style-type: none"> a. the ECRI (economic cycle research institute) recommends a maximum of 130 degrees for blanket warmer temperatures b. the Blickman warmer in the ICU had no thermometer making it impossible to determine the temperature being maintained, but was very hot to touch which could cause a burn to an employee c. it is unknown what the Blickman or Steris/Amsco manufacturers recommend as a maximum blanket warming temperature d. the facility has no policy and procedure for instruction to staff as to the expectation of maximum temperatures of liquids and blankets that are being kept in facility warming cabinets 						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2013

FORM APPROVED

OMB NO. 0938-0391

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