

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
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NAME OF PROVIDER OR SUPPLIER  GIBSON GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
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S 0000  Bldg. 00	This visit was for a State licensure survey of a hospital.  Dates of survey: 09/28/15 to 09/29/15  Facility number: 005019  QA: JL 10/19/15	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 interview, the hospital failed to ensure that 11 directly provided services (outpatient services, social services, housekeeping, post-operative recovery, computed tomography [CT] scans, ultrasound, positive emission tomography	S 0406	There were 11 directly provided services (outpatient, social services, housekeeping, post-operative recovery, computed tomography (CT) scans, ultrasound, positive emission tomography (PET) scans, magnetic resonance imaging (MRI), ophthalmic	11/04/2015

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

TITLE

(X6) DATE

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

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	<p>[PET] scans, magnetic resonance imaging [MRI], ophthalmic surgery, orthopedic surgery and endoscopy) and 2 contracted services (security and tele-radiology) were included in the quality assessment and performance improvement (QAPI) program evaluations for 2015.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the policy &amp; procedure (P&amp;P) titled Quality Improvement Plan, indicated Quality and performance improvement activities will include the monitoring and evaluation of the process and outcomes...These include all departments/services, functions, dimensions of care, and staff. The plan was approved 8/27/15.</li> <li>2. Review of 2015 QAPI meeting minutes and reports lacked documentation of monitors, standards, or evaluations of the directly provided services of outpatient services, social services, housekeeping, post-operative recovery, computed tomography [CT] scans, ultrasound, positive emission tomography [PET] scans, magnetic resonance imaging [MRI], ophthalmic surgery, orthopedic surgery and endoscopy and 2 contracted services for security and tele-radiology.</li> </ol>		<p>surgery, orthopedic surgery, and endoscopy and 2 contracted services (security and tele-radiology) identified during the survey that were not included in the quality assessment and performance improvement program evaluations for 2015. Note: Upon review, positive emission tomography (PET) scans are not completed in this organization and therefore are not addressed. Each department developed a minimum of 2 quality assessment/performance improvement monitors for the above noted service areas. These monitors were taken to the Process Improvement Committee (PIC) on 11/4/15 for review and were approved. Data collection will begin immediately and quarterly reporting to PIC will begin in January of 2016. There were no other service areas identified at PIC that were not currently reporting. The Director of Quality Improvement will continually monitor all service and contracted service areas to assure quality assessment/performance improvement monitors are created and reported in all areas. In December 2015, a new line item on the PIC agenda will be added focusing on new service and contracted service areas and new monitors that need presented. The Director of Quality Improvement will be responsible to assure all</p>	

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S 0408 Bldg. 00	<p>3. On 9/30/15 at 4:00pm, A2, Director of Quality Services, indicated the 11 directly provided services of outpatient services, social services, housekeeping, post-operative recovery, computed tomography [CT] scans, ultrasound, positive emission tomography [PET] scans, magnetic resonance imaging [MRI], ophthalmic surgery, orthopedic surgery and endoscopy and the 2 contracted services for security and tele-radiology did not get reviewed/evaluated by the QAPI program.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</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>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC</p>				<p>departments/services, functions, dimensions of care and staff are monitored and evaluated through the quality assessment and performance improvement program. A review of the above will occur monthly and be ongoing during the monthly PIC committee meetings.</p>		

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	<p>15-1.5-5(b)(3)(L)(i). Based on document review and interview the hospital failed to ensure that the quality assessment and performance improvement (QAPI) program included the 2 functions of response to patient emergencies, and transcription for 2015.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the policy &amp; procedure (P&amp;P) titled Quality Improvement Plan, indicated Quality and performance improvement activities will include the monitoring and evaluation of the process and outcomes...These include all departments/services, functions, dimensions of care, and staff. The plan was approved 8/27/15.</li> <li>Review of 2015 QAPI meeting minutes and reports lacked documentation of monitors, standards, or evaluations for the functions of transcription and response to patient emergencies.</li> <li>On 9/30/15 at 4:00pm, A2, Director of Quality Services, indicated the functions of response to patient emergencies and transcription did not get reviewed/evaluated by the QAPI program.</li> </ol>	S 0408	<p>There were 2 functions (response to patient emergencies and transcription) identified during the survey that were not included in the quality assessment and performance improvement program evaluations for 2015. Each department that was involved in these functions (Emergency Department and Medical Records) developed a minimum of 2 quality assessment/performance improvement monitors for the above noted functions. These monitors were taken to the Process Improvement Committee (PIC) on 11/4/15 for review and were approved. Data collection will begin immediately and quarterly reporting to PIC will begin in January of 2016. There were no other functions were identified at PIC that was not currently reporting. The Director of Quality Improvement will continually monitor all functions to assure quality assessment/performance improvement monitors are created and reported in all areas. In December 2015, a new line item on the PIC agenda will be added focusing on new functions and new monitors that need presented. The Director of Quality Improvement will be responsible to assure all departments/services, functions, dimensions of care and staff are monitored and evaluated through</p>	11/04/2015	

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S 0420 Bldg. 00	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the hospital: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both. (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or</p>		<p>the quality assessment and performance improvement program. A review of the above will occur monthly and be ongoing during the monthly PIC committee meetings.</p>	

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	<p>(BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded:</p> <p>(AA) Objects intentionally implanted as part of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the</p>			

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	<p>hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:                      (i) Infant discharged to the wrong person.                      (ii) Patient death or serious disability associated with patient elopement.                      (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:                      (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:                      (AA) drug;                      (BB) dose;                      (CC) patient;                      (DD) time;                      (EE) rate;                      (FF) preparation; or                      (GG) route of administration.                      Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.                      (ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.                      (iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur</p>			

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	<p>within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy. (iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital. (v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates. (vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar. (vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital. (viii) Artificial insemination with the wrong donor sperm or wrong egg. (E) The following environmental events: (i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion. (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital. (iv) Patient death or serious disability</p>			

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	<p>associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the hospital.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p> <p>Based on document review and interview, the hospital failed to ensure that reportable events were included in the quality assessment and performance improvement (QAPI) program evaluations for 2015.</p> <p>Findings:</p> <p>1. Review of the policy &amp; procedure (P&amp;P) titled Quality Improvement Plan, indicated Quality and performance improvement activities will include the monitoring and evaluation of the process and outcomes...These include all departments/services, functions, dimensions of care, and staff. The P&amp;P also indicated, The following quality and performance improvement activities are included in this plan...Other activities as</p>	S 0420	<p>Reportable Events/Sentinel Events have always been reported to the Risk Manager and quarterly to the Performance Improvement Committee at Gibson General Hospital, however, this reporting has not included the reporting of "0" events during quarters when such events did not occur.</p> <p>All such events will be included in the reporting, including "0" events during quarters with no such occurrences. This on-going reporting was initiated at the PIC on 10/7/15 and at the Safety Committee on 10/16/15. The <i>Reportable Events Reporting Policy and Procedure</i> has been revised to include this additional reporting, and was approved at the Safety Committee on 10/16/15. The policy was sent to Administration on 10/16/15.</p>	10/16/2015			

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S 0554 Bldg. 00	<p>determined by regulatory agencies and hospital leadership. The plan was approved 8/27/15.</p> <p>2. Review of the P&amp;P titled Reportable Events Reporting Policy and Procedure, indicated any reportable events would be reviewed by Risk Management. The P&amp;P lacked documentation of review, evaluation, or inclusion in the QAPI program.</p> <p>3. Review of 2015 QAPI meeting minutes and reports lacked documentation of reportable events having been included in the program.</p> <p>3. On 9/30/15 at 4:00pm, A2, Director of Quality Services, indicated reportable events were not included in the QAPI program.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review, observation, and interview, the hospital failed to provide a safe and healthful environment that minimizes infection exposure and</p>			S 0554	<p>The Hospital Risk Manager will be responsible for continued reporting of the number and nature of reportable events/sentinel events, including "0" events, quarterly to the Performance Improvement Committee (PIC) and monthly to the Safety Committee.</p> <p>During the survey, expired boxes of cereal and crackers were identified. The expired food products were immediately disposed of that day (09/28/15).</p>		11/01/2015

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	<p>risk to patients, health care workers, and visitors in 2 areas (Speech Therapy and clean linen storage).</p> <p>Findings:</p> <p>1. Review of the policy and procedure (P&amp;P) titled Food Storage, indicated the following: Plastic containers with tight-fitting covers or plastic bags must be used for storing cereals/cereal products. The P&amp;P was approved 10/22/13.</p> <p>2. On 9/28/15 between 11:10am and 12:30pm, during facility tour, in the presence of A6, Facility Services Director, the following was observed:</p> <p style="padding-left: 40px;">A. In the clean linen supply room, two walls of linens were observed to be stored on uncovered shelves and the clean towels were noted to be stored uncovered on a long table in front of and up against a wall of exterior windows.</p> <p style="padding-left: 40px;">B. In the presence of A6, Facility Services Director, and S2, Speech Pathologist, on a shelf, inside a cabinet of the Speech therapy area in Rehabilitative Therapy unit was a cardboard box of Honey Nut Spins Cereal with an expiration date indicated as 03/24/15, a box of Golden Wafers with an expiration date indicated as 01/27/15, a box of Club Crackers with an expiration date</p>		<p>A shelf was designated for storage of food products for patient use only on 10/10/15. The department transitioned to individually packaged food products the same day (10/10/15). Rehab staff was educated on new food storage process during the October staff meeting (10/15/15). No client was directly affected. A review of the entire department was completed the day of the survey (09/28/15) and there were no other expired food products or food products being stored in bulk packaging. The rehab staff was educated on the new food storage process during our October staff meeting (10/15/15). We will continue to re-enforce the proper process with staff during the November and December monthly rehab staff meetings. A new policy for food storage in rehab department was developed on 11/01/15. The rehab director or an appointed designee will monitor expiration dates of all food products in the rehab department monthly and report these findings quarterly to the Performance Improvement Committee (PIC) starting in October 2015. Frequency of audits: Monthly Denominator: # of months tracked thus far in year Numerator: # months compliant Goal: 95% compliance The rehab director is responsible for assuring that there are no expired food products within the rehab</p>		

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	<p>indicated as 01/17/15, and a box of Buttery Crackers with an expiration date indicated as 01/06/15.</p> <p>3. On 9/28/15 at 11:45am, S2 indicated the 2 boxes of cereal and 2 boxes of crackers were expired and should have been discarded.</p>		<p>department. Monitoring will be done monthly using the Rehab Food Expiration Tracking sheet.</p> <p>In the clean linen supply room, 2 walls of linen were noted to be stored on uncovered shelves and the clean towels were noted to be stored uncover on a long table in front of and up against a wall of exterior windows. The towels stored on the table in front of the window were removed and all of the shelves in the clean linen room were covered with clean sheets on 9/30/15. All Housekeeping staff attended an in-service on 10/26/15 regarding appropriate storage in the clean linen supply room and other clean linen areas of the hospital. Laundry and Linen Procedures were updated and reviewed at the time of this meeting. All clean linen areas of the hospital were audited by the Environmental Services (EVS) Manager to assure all clean linen was properly covered. All areas that contain clean linen were found to be appropriately covered and stored. A clean linen supply room audit will be performed by the EVS Manager or designee. This will be audited daily for one month, weekly for six months, then monthly for six months. This will ensure compliance of keeping clean linen covered and prevent the deficient from recurring. The monitoring will be done by the EVS Manager or designee. Audit and findings will be reported to</p>		

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S 0596 Bldg. 00	<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 document review, observation, and interview, the Infection Control Committee failed to ensure environmental services were provided in a manner that ensured the prevention of transmission of disease to staff and patients.</p> <p>Findings include:</p> <p>1. Review of the facility policy "Housekeeping Infection Control Plan", last reviewed 09/16/15, indicated, "Germicidal disinfectants, when properly used, are very helpful in infection control. The approved germicidal</p>	S 0596	<p>PIC quarterly. Goal of 100% compliance.</p> <p>During the survey, it was noted the infection control committee failed to ensure environmental services were provided in a manner that ensured the prevention of transmission of disease to staff and patients. Trial product Prominence was removed from the janitor's closet at the surgery extension at the time of the survey on 9/29/15. The same chemical utilized in the surgery department at the hospital (Virex II 256) was placed at the surgery extension for use on 9/29/15. Proper mixing instructions of Virex II 256 were posted and measuring cups were placed in the 2 Janitor's closet at the extension with instructions to</p>	11/18/2015

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	<p>disinfectant is a quaternary product. The proper dilution is 1/2 ounce of disinfectant to one gallon cold water."</p> <p>2. Signage posted in the housekeeping closets indicated, "Use the 3H Neutral Cleaner Friday thru Wednesday. Use the 23H Disinfectant Thursdays Only".</p> <p>3. The manufacturer's Safety Data Sheet for Prominence Heavy Duty Floor Cleaner discussed properties of the chemical at a dilution of 1:64, but the sheet did not discuss any mixing directions. Written on the sheet was "1 oz. per gallon" and initialed by staff member A15, the EVS (Environmental Services) Manager.</p> <p>4. During the tour of the inpatient unit at 10:40 AM on 09/28/15, accompanied by staff member A1, the Chief Nursing Officer, staff member A10, the EVS worker on the unit, was interviewed. He/she indicated he/she fills the mop bucket and the small container for surface cleaning with the 3H Neutral Cleaner via the automated dispenser in the janitor's closet. He/she indicated he/she added 1/4 cup of Virex TB to the small bucket and 1/2 cup of Virex TB to the mop bucket for disinfection. He/she indicated he/she did not measure the amounts. The container of Virex TB indicated the</p>		<p>rinse out cups between uses. Environmental service (EVS) staff member A10, on the inpatient unit at the time of survey, was given individualized education and instructions by EVS Manager at time of survey on proper chemical mixing. An in-service for all EVS staff was held on 10/26/15, to reeducate regarding appropriate infection control measures and proper chemical mixing measures for all chemicals utilized by EVS staff. Special attention was given to the use of Virex TB ready to use (RTU). EVS Manager reviewed the policy titled "Housekeeping Infection Control Plan". Representatives from 3M hospital floor care were contacted immediately regarding the appropriate practice of hospital floor care products. It was confirmed that the practice of hospitals use of the 3M products include the 3M Neutral floor cleaner being used daily and 3M disinfectant being used one time per week in areas other than patient care rooms. Two other large regional tertiary hospital's infection control departments confirmed they both utilize this process. Review and approval of cleaning and disinfectant products: Prominence (floor cleaner), Virex Plus(floors in surgery and after every patient discharge from a room - floors and surfaces), Oxivir five 16(surfaces), Crew NA (toilets) and Glance HC (window cleaner)</p>	

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	<p>product was a RTU (ready-to-use) product and the label did not list any dilution directions.</p> <p>5. During the tour of the Surgery Extension at 12:25 PM on 09/28/15, accompanied by staff members A12, the Director of Surgery, and A13, a surgical nurse, containers of Virex RTU with no measuring cups were observed in one janitor's closet, and a container of Prominence (a yellow solution) with a measuring cup with dried yellow material were observed in the other janitor's closet. Both nurses confirmed there were no mixing directions on the label of the Prominence solution.</p> <p>6. At 1:50 PM on 09/28/15, staff member A15, the EVS Manager, indicated Prominence was a trial product and he/she was unsure about the dilution or mixing instructions. He/she indicated all surfaces should be cleaned with the disinfectant and not the Neutral cleaner. He/she confirmed the floors were only cleaned with the disinfectant once a week and he/she was not sure why.</p> <p>7. At 2:30 PM on 09/28/15, staff member A6, the Facilities Services Director, indicated the chemical representative advised the facility to only use the disinfectant once a week to</p>		<p>occurred on 11/4/15 at the Infection Control Committee and 11/11/15 at the Department of Medicine. All in-services on these products are to be completed by 11/18/15 for all EVS staffing. System changes will include installation of J-fill pre-measured stations from Diversity in 9 janitor closets throughout the hospital and the surgery extension. This installation will occur 11/13/15 by a Diversity Representative. In-service reeducation will occur on the use of the J-fill pre-measured stations for all EVS staffing will be completed by 11/18/15. Proper chemical mixing verification will be done via direct observation by the EVS Manager, or assigned designee, monthly for each EVS staff member to assure proper chemical use, mixing, use of premeasured stations, labeling, and hose connections. Instructions and visuals will be placed in each janitor's closet. The EVS Manager, or assigned designee, will be responsible for monitoring the 9 closets on a weekly basis regarding the J-fill stations and hose connections being intact. Each EVS staff member will be visually monitored monthly for proper chemical use, mixing, use of premeasured stations, and labeling. These monitors will be reported to PIC quarterly. Goal of 95%.</p>	

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S 0610 Bldg. 00	<p>protect the floors and indicated this had been going on for at least 5 years. He/she did not know if this practice had been approved by the Infection Control Committee.</p> <p>8. At 8:30 AM on 09/29/15, staff member A2, the Director of Quality and Infection Preventionist, indicated he/she was not aware of the mopping with disinfectant only once a week and indicated the practice had not been approved by the Infection Control Committee. He/she was also unaware of the trial product at the Surgery Extension or how to use it. He/she confirmed the issues with the chemicals and disinfection practices.</p> <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</p>				

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	<p>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 document review, observation, and interview, the infection control committee failed to ensure food storage was per policy &amp; procedure (P&amp;P) for 4 foods (2 boxes of cereal and 2 boxes of crackers) in 1 area (Speech Therapy).</p> <p>Findings:</p> <p>1. Review of the P&amp;P titled Food Storage, indicated the following: Plastic containers with tight-fitting covers or plastic bags must be used for storing cereals/cereal products. The P&amp;P was approved 10/22/13.</p> <p>2. On 9/28/15 between 11:10am and 12:30am during facility tour, the following was observed: In the presence of A6, Facility Services Director, and S2, Speech Pathologist, on a shelf, inside a cabinet of the Speech therapy area in Rehabilitative Therapy unit was a cardboard box of Honey Nut Spins Cereal with an expiration date indicated</p>	S 0610	<p>During the survey, expired boxes of cereal and crackers were identified. The expired food products were immediately disposed of that day (09/28/15). A shelf was designated for storage of food products for patient use only on 10/10/15. The department transitioned to individually packaged food products the same day (10/10/15). Rehab staff was educated on new food storage process during the October staff meeting (10/15/15). No client was directly affected. A review of the entire department was completed the day of the survey (09/28/15) and there were no other expired food products or food products being stored in bulk packaging. The rehab staff was educated on the new food storage process during our October staff meeting (10/15/15). We will continue to re-enforce the proper process with staff during the November and December monthly rehab staff meetings. A new policy for food storage in rehab department was developed</p>	11/01/2015

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S 0744 Bldg. 00	<p>as 03/24/15, a box of Golden Wafers with an expiration date indicated as 01/27/15, a box of Club Crackers with an expiration date indicated as 01/17/15, and a box of Buttery Crackers with an expiration date indicated as 01/06/15.</p> <p>3. On 9/28/15 at 11:45am, S2 indicated the 2 boxes of cereal and 2 boxes of crackers were expired and should have been discarded. He/she did not indicate the boxes were required to be kept inside a plastic container.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on document review, medical record review, and interview, the facility failed to ensure all patient records were accurate and complete for 4 of 16 closed records reviewed (#N2, N6, N8, and N9).</p> <p>Findings include:</p> <p>1. Review of the facility policy "Physician Orders", last revised 02/12/14, indicated, "Physician's orders are</p>	S 0744	<p>on 11/01/15. The rehab director or an appointed designee will monitor expiration dates of all food products in the rehab department monthly and report these findings quarterly to the Performance Improvement Committee (PIC) starting in October 2015. Frequency of audits: Monthly Denominator: # of months tracked thus far in year Numerator: # months compliant Goal: 95% compliance The rehab director is responsible for assuring that there are no expired food products within the rehab department. Monitoring will be done monthly using the Rehab Food Expiration Tracking sheet.</p> <p>Chart audit, during the survey, revealed that the "Code Status Consent Forms" and physician written and/or electronic orders regarding code status were found to be inconsistent. The policy regarding Advanced Directives was reviewed and updated to reflect a consistent method of obtaining a code status order. This policy will be taken to the Medical Executive Committee on 11/18/2015 for final approval. All current patients charts, and</p>	12/03/2015

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	<p>interpreted, processed and incorporated in the plan of patient care by appropriate personnel. Licensed professionals are responsible for the accurate transcription and interpretation of the physician's written orders."</p> <p>2. Review of the facility policy "Patient Rights- Advance Directives", last reviewed 11/06/14, indicated, "6. It is the responsibility of the attending physician to incorporate the provisions of the advance directive into the patient's medical treatment plan, or refer that patient to a physician who will." The facility form "Code Status Consent Form" indicated a line for the patient's name (or decision maker) with the text that the physician had discussed the patient's condition and the procedures/treatments listed below. The four choices listed were: Do Not Resuscitate (DNR), Medical Code, Full Code, and No Choice at This Time. Signature lines were provided for the patient/family member/ legal representative, facility representative, and attending physician, with dates.</p> <p>3. Medical record #N2 indicated a written physician order for a transfer on 05/08/15 that lacked any notation that it had been transcribed although the order was carried out.</p>		<p>ongoing, have been audited to assure the "Code Status consent Forms" are on each chart and all areas addressed on the form are completed. In- services regarding the revision of the Advanced Directive policy will be conducted for all nursing staff members on Medical/Surgical and ICU during the unit meetings for December on 12/3/15 and reinforced during the January unit meetings on 1/7/16. All new admission charts will be reviewed by the team leader/charge nurse to ensure completion of the "Code Status Consent Form". Medical Surgical Manager will be responsible for monthly chart audits to ensure compliance with revised policy. A monthly 10% chart audit will be completed from admissions that month. Results will be reported to the Performance Improvement Committee (PIC) on a quarterly basis. Target goal of 90% compliance. Chart audit, during the survey, revealed that the "Burial Transit Permit Forms" were found to be inconsistent. Chart audit revealed that a physician order regarding a patient transfer and several physician orders regarding the release of body to funeral a home were written but lacked notation that it had been transcribed by the nursing staff. In- services to reeducate nursing staff regarding notation that an order has been transcribed by the nursing staff will be conducted for all nursing</p>				

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	<p>4. Medical record #N6 indicated a written physician order to release the body to the funeral home on 06/23/15 that lacked any notation that it had been transcribed although the order was carried out. The record also contained a "Provisional Notification of Death-Burial Transit Permit" that was incompletely filled out by facility staff.</p> <p>5. Medical record #N8 indicated a written physician order to release the body to the funeral home on 06/13/15 that lacked any notation that it had been transcribed although the order was carried out. The record also contained a "Provisional Notification of Death-Burial Transit Permit" that was incompletely filled out by facility staff. The record contained a "Code Status Consent Form" for a Medical Code, signed by a family member and a registered nurse on 06/06/15, and by a physician on 06/08/15. The History and Physical, dictated by the physician on 06/07/15, indicated, "The patient's family decided for [him/her] to be Do Not Resuscitate." The record lacked any additional "Code Status Consent Form".</p> <p>6. Medical record #N9 indicated a "Provisional Notification of Death-Burial Transit Permit" that was</p>		<p>staff members on Medical/Surgical and ICU during the unit meetings for December on 12/3/15 and ED unit meetings on 11/26/15. The policy regarding Care of the Dying has been reviewed and updated. The policy states a Nursing Death Check List will be completed on all patients that pass away at Gibson General Hospital. This checklist is designed to ensure that all proper entities, personnel, and forms are contacted and/or completed as necessary. An in-service was conducted with all nursing staff members on Medical/Surgical and ICU on 11/5/2015 during the unit meeting. Staff was reeducated regarding the use of the "Burial Transit Permit Form" the new Nursing Death Check List, Autopsy Policy and Procedure and request form if needed, Coroners Case Policy and Procedure, the Organ Procurement Approval/Declination Form, and The Provisional Notification –Burial Transit Form. In-servicing is being conducted with all nursing staff members of the ED on the same and will be completed by 11/19/15. Copies of all completed forms and the Nursing Death Check List will be given to the Medical Surgical Manager and the ED manager. The Managers will audit all received forms for proper completion and compliance with</p>				

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	<p>incompletely filled out by facility staff. The record contained two "Code Status Consent Forms", both signed by a family member and a registered nurse on 06/24/15, and one was signed by a physician on 07/11/15, but none of the four choices on the forms was marked. A physician progress note from 1103 hours on 06/26/15 indicated the patient's condition and prognosis were discussed with the patient's power of attorney, but he/she wanted to continue with the current management and see how the patient did. Documentation indicated a verbal physician order for a DNR was entered into the EMR (Electronic Medical Record) at 1550 hours on 06/26/15. The patient expired on 06/27/15.</p> <p>7. At 1:10 PM on 09/29/15, staff member A19, Manager of the Med/Surg Unit, indicated all written orders should be signed and dated as noted by the registered nurse.</p> <p>8. At 1:50 PM on 09/29/15, staff members A2, the Quality Director, and A18, the Medical Records staff, confirmed the incomplete forms and the discrepancies with the DNR documentation in the medical records.</p>		revised policy. Results will be reported to the Performance Improvement Committee (PIC) on a quarterly basis. Target goal of 95% compliance.	

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S 0804  Bldg. 00	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(1) Conduct outcome oriented performance evaluations of its members at least biennially.</p> <p>Based on document review and interview, the medical staff (MS) failed to conduct biennial outcome oriented performance evaluations for 3 of 4 reappointed physician MS members and 2 of 3 reappointed allied health (AH) MS members.</p> <p>Findings:</p> <p>1. Review of reappointed MS members (MD#2, MD#4, and MD#5) and reappointed AH MS members (AH#1 and AH#2) credential files lacked documentation of a biennial evaluation(s).</p> <p>2. On 9/29/15 at 10:00am A17, Medical Staff Coordinator, indicated physician</p>	S 0804	<p>Upon document review and interview, the medical staff failed to conduct biennial outcome oriented performance evaluations for 3 of 4 reappointed physicians and 2 of 3 Allied Health members. MD #2: An Occupational Health physician - Quality measures for Occupational Medicine have been developed and will be taken for approval to Credentials Committee on 12/7/15 (committee serves as Peer Review body), Department of Medicine on 12/9/15, Medical Executive Committee on 12/16/15. Upon approval, retrospective quality data will be collected for 2014 and 2015. This data will then take the same path (Credentials, Department of Medicine, and Medical Executive) in the first quarter of 2016. MD</p>	03/31/2016

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	<p>and CRNA (certified registered nurse anesthetist) MS performance evaluations are not included in the credential files, but do show up as a quality report.</p> <p>3. Review of MS performance/quality evaluations lacked documentation of a biennial evaluation for MD#2, MD#4, MD#5, AH#1 or AH#2.</p> <p>4. On 9/29/15 at 12:45pm A17 indicated documentation of MD#2, MD#4, MD#5, AH#1, &amp; AH#2 was not available.</p>		<p>#4: General Surgeon - Physician has been out of the country for an extended period of time on medical missions and working with contractors of medical care for military missions. He has no other current hospital affiliations to request data from. The Surgery Committee officially placed him on hiatus from Surgery Committee on 4/10/15 after being out of country and no activity since 12/11/13. (No cases in 2014 or 2015) Data is not currently being collected due to above. If the physician returns to practice, quality information will be collected. MD #5: ED physician (physician on staff with no activity) Quality data from other current hospital affiliation received 11/10/15 for 2014 and 2015; to be taken to Credentials Committee 12/7/15, Department of Medicine on 12/9/15, and Medical Executive on 12/16/15 for review. AH #1: Nurse Practitioner - Current competency on file by 11/5/15 for biennial evaluation. This data will be taken to the Credential Committee on 12/7/15, Department of Medicine on 12/9/15, and Medical Executive on 12/16/15. AH #2: Nurse Practitioner - Not currently practicing here and no quality data available from other current hospital affiliations. A Competency Assessment form for Low/No Volume Practitioners has been developed and will be taken for approval to Credentials</p>		

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			<p>Committee on 12/7/15, Department of Medicine on 12/9/15, and Medical Executive Committee on 12/16/15. Approved form will be sent to practitioner's place of employment to be filled out by sponsoring physician and returned to the Medical Staff Coordinator within the designated number of days. Under the Ongoing Professional Practice Evaluation (OPPE) process, quality data for all practitioners reviewed every six months and at reappointment. A Current Competency Attestation and Peer Evaluation form has been developed for Low/No Volume Practitioners and will be taken for approval to Credentials Committee on 12/7/15, Department of Medicine on 12/9/15, and Medical Executive Committee on 12/16/15. These forms will be then utilized and sent to all practitioners who fit this profile two times per year and at reappointment time. List of all practitioners is divided into six groups of approximately 20-25 each to cover the required six-month reporting period. A spreadsheet has been developed to monitor the sending of notices and receipt of data. Medical Staff Coordinator will monitor quality data monthly. Review of quality data is performed every six months and at reappointment; this monitor will be reported quarterly at the Performance</p>	

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S 0812  Bldg. 00	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(4)(A)(B)(C)(D)(E)(F)(G)(H)(I)(J)(K)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(4) Maintain a file for each member of the medical staff that includes, but is not limited to, the following:</p> <p>(A) A completed, signed application. (B) The date and year of completion all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A copy of the member's current Indiana license showing the date of licensure and current number or an available certified list provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the medical licensing board. (D) A copy of the member's current Indiana controlled substance registration showing the number, as applicable.</p>		Improvement Committee meeting. Monitoring will be done on a continuous basis. Goal of 90%.	

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	<p>(E) A copy of the member's current Drug Enforcement Agency registration showing the number, as applicable</p> <p>(F) Documentation of experience in the practice of medicine.</p> <p>(G) Documentation of specialty board certification, as applicable.</p> <p>(H) Category of medical staff appointment and delineation of privileges approved.</p> <p>(I) A signed statement to abide by the rules of the hospital.</p> <p>(J) Documentation of current health status as established by hospital and medical staff policy and procedure and federal and state requirements.</p> <p>(K) Other items specified by the hospital and medical staff.</p> <p>Based on document review and interview, the medical staff (MS) failed to include a signed statement to abide by the rules of the hospital in each MS members file for 10 of 10 MS credential files (MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, AH#1, AH#2, AH#3, and AH#4).</p> <p>Findings:</p> <p>1. Review of 10 MS members credential files (MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, AH#1, AH#2, AH#3, and AH#4) lacked documentation of a signed statement, by each member, to abide by the rules of the hospital.</p> <p>2. On 9/29/15 at 12:30pm, A17, Medical</p>	S 0812	<p>During the survey, it was noted that the medical staff (MS) failed to include a signed statement to abide by the rules of the hospital in each MS members file for 10 of 10 credential files (MD #1, MD #2, MD #3, MD #4, MD #5, MD #6, AH #1, AH #2, AH #3, AH #4). The Medical Staff Coordinator was unable to locate the statement for the surveyors. Upon further review after departure of surveyors, the following statement was noted to be on the Applicant Statement Consent Release and Authorization: "In making application for appointment/reappointment to any Participating Entity, I agree to abide by applicable Participating Entity's bylaws, rules, and policies, its medical staff's bylaws, rules and regulations, and</p>	09/29/2015

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S 0936 Bldg. 00	<p>Staff Coordinator, indicated the MS credential files did not contain a signed statement, by the members, to abide by the rules of the hospital.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(6)</p> <p>(b) The nursing service shall have the following:</p> <p>(6) All nursing personnel shall demonstrate and document competency in fulfilling assigned responsibilities. Based on document review and interview, the facility failed to ensure 2 of 2 Emergency Department (ED) nurses had documentation of all required nursing competencies (#P3 and P4).</p> <p>Findings included:</p> <p>1. Review of the facility policy "ER</p>	S 0936	<p>policies and procedures." All 10 credential files (MD #1, MD #2, MD #3, MD #4, MD #5, MD #6, AH #1, AH #2, AH #3, AH #4) were reviewed and the statement was in each of the files and signed by the provider. This statement is found on all appointment and reappointment applications. As this was not a deficient practice but an oversight, no changes in process need to be made. Medical Staff Coordinator will on an ongoing basis will monitor and confirm existence of statement on application during review of credentialing file at times of appointment and reappointment. Goal of 100%.</p> <p>Upon review and interview, the facility failed to ensure 2 of 2 Emergency Department nurses had documentation of all required nursing competencies. An audit was completed on all nursing staff to ascertain what required certifications were current or expired. Any required certifications that were found to be expired will be completed by</p>	12/31/2015

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	<p>[Emergency Room] Nursing Staff", last revised 02/04/14, indicated, "3. All ER Personnel must be certified in Health Care Provider CPR [Cardiopulmonary Resuscitation] according to the American Heart Association Guidelines. 4. All ER RNs [Registered Nurses] must be certified in Advanced Cardiac Life Support (ACLS) according to the American Heart Association Guidelines. 5. RNs will follow policy #860-9805 of the Gibson General Hospital policy manual with regard to TNCC [Trauma Nursing Core Course], ENPC [Emergency Nursing Pediatric Course], PALS [Pediatric Advanced Life Support], and NRP [Neonatal Resuscitation Program]."</p> <p>2. Review of the facility policy "Plan for Provision of Patient Care and Services", last reviewed 11/06/14, indicated, "The Emergency Care Unit offers emergency health services 24 hours a day to patients of all ages. ... Requirements for Personnel: The basic requirements for RNs are: Current State Licensure. ER experience pre-hire or by established orientation. BLS; ACLS; PALS; NRP; TNCC; ENPC."</p> <p>3. Review of the personnel file for staff member P3, an Emergency Department RN hired 11/11/97, indicated a job</p>		<p>12/31/15. Registered Nurse Job Descriptions were updated to reflect the appropriate certifications and educational requirement. Each nursing department developed policies to reflect required certifications needed for each department based upon the patient population they serve. The "Plan for Provision of Patient Care and Services" has also been reviewed and updated to reflect the update. All Registered Nurses in the hospital will sign the newly updated Job Description with appropriate certifications attached by 12/31/15. To assure every Registered Nurse maintains required certifications; Managers/Directors of each nursing department will complete monthly audits of every RN for expired or soon to be expired certifications. It will be the responsibility of each Registered Nurse to maintain required certification; it is the Managers/Directors responsibility to assure they are verified. Human Resources will have every Registered Nurse sign an appropriate Job Description on a yearly basis. The respective Manager/Director will check all certifications monthly and will report to Process Improvement Committee on a quarterly basis. Goal 100%</p>		

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	<p>description which indicated, "7. Maintains current Indiana Licensure and CPR/ACLS/TNCC/PALS/NRP certification as identified in the hospital policy." The file lacked documentation of TNCC and NRP certifications.</p> <p>4. Review of the personnel file for staff member P4, an Emergency Department RN hired 06/25/07, indicated a job description which indicated, "7. Maintains current Indiana Licensure and CPR/ACLS/TNCC/PALS/NRP certification as identified in the hospital policy." The file lacked documentation of TNCC or a current NRP certification. The file contained an expired NRP card from 2013.</p> <p>5. At 3:35 PM on 09/29/15, staff member A7, the Human Resources Assistant, confirmed the lack of all the education requirements for the Emergency Department nurses.</p> <p>6. At 4:00 PM on 09/29/15, staff member A1, the Chief Nursing Officer, indicated he/she was unable to access the old policy that was referenced in the ER Nursing Staff policy, but confirmed the expectation was for the ER nurses to have CPR/ACLS/PALS/NRP certifications and to obtain the others whenever possible.</p>			

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S 1118 Bldg. 00	<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 observation and interview, the hospital created or maintained a condition that may result in a hazard to patients, public, or employees in 2 areas (building B mechanical room and the boiler room).</p> <p>Findings:</p> <p>1. On 9/28/15 between 11:10pm and 12:30pm during facility tour, in the presence of A6, Facility Services Director, in building B mechanical room a 45 lb container label as Corshield D "TOXIC" was observed sitting on the floor near the rear of the room and on the floor in another area of the room was a 5 gallon container labeled as Aluminum Cleaner "TOXIC".</p>	S 1118	All bulk chemicals were removed from all mechanical rooms and stored in a bulk chemical storage containment tub located in the main boiler room on 10/2/15. By removing the bulk chemicals from individual mechanical rooms and placing them in a central storage location we are able to monitor the chemicals and provide a safe storage location for the chemicals. It will also be easier to monitor the bulk chemical inventory by storing them in one location. All maintenance staff was involve in collecting the chemicals and creating a central storage location. All mechanical rooms were audited to assure no other bulk chemicals were located outside of the bulk chemical storage containment tub. All maintenance staff attended an in-service on 10/2/15 where the use of bulk chemicals,	10/02/2015

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	<p>2. On 9/28/15 at 12:15, A6 indicated the TOXIC containers should be stored in a secured area, not on the floor of the mechanical room.</p> <p>3. On 9/29/15 between 12:30pm and 1:30pm during facility tour, in the presence of A6, in water testing area of the boiler room the following was observed: 2 small bottles indicated to contain testing chemicals Hardness Titrant and Conductivity Standard with no expiration date noted. Larger bottles of testing chemicals were observed as follows: Hardness Titrant, expiration date 02/2005; Trace Hardness Titrant, expiration date 9/2013; Conductivity Standard, expiration 4/2011.</p> <p>4. On 9/29/15 at 12:45pm A6 indicated the chemicals in the small bottles did not expire. A6 also indicated the larger bottles did indicate an expiration date.</p>		<p>there storage and monitoring was discussed. A PM to monitor all 10 mechanical rooms within the facility was created to inventory and monitor all bulk chemicals that are used, assuring they are in the bulk chemical storage containment tub and not located outside of the tub. The director of facility services, or their designate, will perform the PM on a monthly basis and report to the Process Improvement Committee quarterly. Goal: 10/10=100% All water testing chemicals found to be out dated were refreshed with bottles relabeled to reflect the new expiration date. The chemicals that were out dated were for testing boiler water. Facilities Staff that are involved in performing the water test were in-serviced on 10/2 /15 to check the bottles for expiration dates prior to using the chemicals. The vendor who provides the water testing chemicals will notify facilities staff each time a chemical is refreshed and indicate the new expiration date for the new chemical on the smaller bottles. This will be recorded by the facility maintenance manager in the chemical log. A monthly PM has been created on the chemical log for the water treatment test chemicals to assure the expiration date is current. All boiler water treatment chemicals will be monitored monthly and be reported to PIC quarterly. There</p>	

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S 1164 Bldg. 00	<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 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. Based on observation, and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 5 pieces of equipment (rebounder, stepper, ceiling mount swing, photo simulator #3309 and floor scrubber #001034).</p> <p>Findings:</p> <p>1. On 9/28/15 between 11:10am and 12:30pm during facility tour the following was observed: In the rehabilitation department, in the presence of A6, Facility Services Director, and S1, Manager Cardiopulmonary Services was rebounder, a Cybex stepper, and a ceiling mount therapy swing. In the sleep lab was a photo simulator with a biomedical</p>			S 1164	<p>are 8 reagents that are used to test the boiler water. The goal is 100 % compliance. 8/8 each month = 100%</p> <p>The hospital failed to provide evidence of preventive maintenance for 5 pieces of equipment (rebounder, stepper, ceiling mount swing, photo simulator and floor scrubber). Manufacturer's recommendations were reviewed for all 5 pieces of equipment noted above. Asset tags were placed and PM's were developed for all 5 pieces of equipment and completed on 11/12/15. Throughout the facility, we will continually monitor for any asset that is not tagged. A line item will be added to the currently utilized Environment of Care monthly audit sheets that ask the manager and directors to continuously monitor for any asset that is not tagged. If something is found, they are to</p>		11/12/2015

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	<p>preventive maintenance sticker indicated with the last PM as 10/13 #3309.</p> <p>2. On 9/29/15 between 12:30pm and 1:30pm during facility tour, in building B mechanical room, in the presence of A6, floor scrubber with asset identification #001034 was observed.</p> <p>3. Review of 2014-2015 preventive maintenance documentation lacked evidence of PM for a rebounder, Cybex stepper, ceiling mount therapy swing, photo simulator, or floor scrubber.</p> <p>4. On 9/29/15 at 9:00am documentation was presented indicating PM was done 9/29/15 on the photo simulator. Documentation of PM between 10/13 and 9/29/15 was not available.</p> <p>5. On 9/28/15 at 3:40pm A16, Director of Rehabilitation, indicated PM was not performed by the department on the rebounder, Cybex stepper, or the ceiling mount therapy swing.</p> <p>6. On 9/29/15 at 2:00pm S3, Facilities Manager, indicated PM was not indicated for floor scrubber #001034 and the manufacturer manual was not available. S3 further indicated PM documentation for the photo simulator between 10/13 and 9/29/15 was not available and that no</p>		<p>notify facilities services so they can tag the item and determine if a PM is required based upon manufacturer's recommendations. A Gate keeping process has also been put into place to prevent the deficiency from reoccurring. Any asset that comes into the facility is delivered to facilities services or materials management. Both areas are aware that facilities services are to provide an asset tag, log the equipment into the asset list and develop a PM if required. This will assure all equipment coming into the facility will have PM's if required. All materials management staff have been in-serviced on this process by 11/12/15. Also, during new employee orientation, staff will be educated regarding asset tagging and PM's. The Facilities Manager will monitor the number of PM's that are scheduled each month and the number that is completed. The Manager will also monitor the number of deficient asset tags and PM's that are reported monthly. This will be reported at the Process Improvement committee on a quarterly basis. Goal: 95% of PM assigned / PM completed per quarter. Goal: 100% of deficient asset tags and PM reported monthly are completed within the month.</p>	

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S 1172 Bldg. 00	<p>PM documentation was available for the rebounder, ceiling mount swing, or stepper. S3 indicated the facility did not have a policy in place for preventive maintenance of equipment.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on document review, manufacturer directions, observation, and interview, the facility failed to ensure environmental services were provided in a manner that ensured the prevention of transmission of disease to staff and patients.</p> <p>Findings included:</p> <p>1. Review of the facility policy</p>	S 1172	<p>During the survey, it was noted the infection control committee failed to ensure environmental services were provided in a manner that ensured the prevention of transmission of disease to staff and patients. Trial product Prominence was removed from the janitor's closet at the surgery extension at the time of the survey on 9/29/15. The same chemical utilized in the surgery department at the</p>	11/18/2015

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	<p>"Housekeeping Infection Control Plan", last reviewed 09/16/15, indicated, "Germicidal disinfectants, when properly used, are very helpful in infection control. The approved germicidal disinfectant is a quaternary product. The proper dilution is 1/2 ounce of disinfectant to one gallon cold water."</p> <p>2. Signage posted in the housekeeping closets indicated, "Use the 3H Neutral Cleaner Friday thru Wednesday. Use the 23H Disinfectant Thursdays Only".</p> <p>3. The manufacturer's Safety Data Sheet for Prominence Heavy Duty Floor Cleaner discussed properties of the chemical at a dilution of 1:64, but the sheet did not discuss any mixing directions. Written on the sheet was "1 oz. per gallon" and initialed by staff member A15, the EVS (Environmental Services) Manager.</p> <p>4. During the tour of the inpatient unit at 10:40 AM on 09/28/15, accompanied by staff member A1, the Chief Nursing Officer, staff member A10, the EVS worker on the unit, was interviewed. He/she indicated he/she fills the mop bucket and the small container for surface cleaning with the 3H Neutral Cleaner via the automated dispenser in the janitor's closet. He/she indicated he/she added 1/4</p>		<p>hospital (Virex II 256) was placed at the surgery extension for use on 9/29/15. Proper mixing instructions of Virex II 256 were posted and measuring cups were placed in the 2 Janitor's closet at the extension with instructions to rinse out cups between uses. Environmental service (EVS) staff member A10, on the inpatient unit at the time of survey, was given individualized education and instructions by EVS Manager at time of survey on proper chemical mixing. An in-service for all EVS staff was held on 10/26/15, to reeducate regarding appropriate infection control measures and proper chemical mixing measures for all chemicals utilized by EVS staff. Special attention was given to the use of Virex TB ready to use (RTU). EVS Manager reviewed the policy titled "Housekeeping Infection Control Plan". Representatives from 3M hospital floor care were contacted immediately regarding the appropriate practice of hospital floor care products. It was confirmed that the practice of hospitals use of the 3M products include the 3M Neutral floor cleaner being used daily and 3M disinfectant being used one time per week in areas other than patient care rooms. Two other large regional tertiary hospital's infection control departments confirmed they both utilize this process. Review and approval of cleaning and disinfectant</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>cup of Virex TB to the small bucket and 1/2 cup of Virex TB to the mop bucket for disinfection. He/she indicated he/she did not measure the amounts. The container of Virex TB indicated the product was a RTU (ready-to-use) product and the label did not list any dilution directions.</p> <p>5. During the tour of the Surgery Extension at 12:25 PM on 09/28/15, accompanied by staff members A12, the Director of Surgery, and A13, a surgical nurse, containers of Virex RTU with no measuring cups were observed in one janitor's closet, and a container of Prominence (a yellow solution) with a measuring cup with dried yellow material were observed in the other janitor's closet. Both nurses confirmed there were no mixing directions on the label of the Prominence solution.</p> <p>6. At 1:50 PM on 09/28/15, staff member A15, the EVS Manager, indicated Prominence was a trial product and he/she was unsure about the dilution or mixing instructions. He/she indicated all surfaces should be cleaned with the disinfectant and not the Neutral cleaner. He/she confirmed the floors were only cleaned with the disinfectant once a week and he/she was not sure why.</p>		<p>products: Prominence (floor cleaner), Virex Plus(floors in surgery and after every patient discharge from a room - floors and surfaces), Oxivir five 16(surfaces), Crew NA (toilets) and Glance HC (window cleaner) occurred on 11/4/15 at the Infection Control Committee and 11/11/15 at the Department of Medicine. All in-services on these products are to be completed by 11/18/15 for all EVS staffing. System changes will include installation of J-fill pre-measured stations from Diversity in 9 janitor closets throughout the hospital and the surgery extension. This installation will occur 11/13/15 by a Diversity Representative. In-service reeducation will occur on the use of the J-fill pre-measured stations for all EVS staffing will be completed by 11/18/15. Proper chemical mixing verification will be done via direct observation by the EVS Manager, or assigned designee, monthly for each EVS staff member to assure proper chemical use, mixing, use of premeasured stations, labeling, and hose connections. Instructions and visuals will be placed in each janitor's closet. The EVS Manager, or assigned designee, will be responsible for monitoring the 9 closets on a weekly basis regarding the J-fill stations and hose connections being intact. Each EVS staff</p>	

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S 2116 Bldg. 00	<p>7. At 2:30 PM on 09/28/15, staff member A6, the Facilities Services Director, indicated the chemical representative advised the facility to only use the disinfectant once a week to protect the floors and indicated this had been going on for at least 5 years. He/she did not know if this practice had been approved by the Infection Control Committee.</p> <p>8. At 8:30 AM on 09/29/15, staff member A2, the Director of Quality and Infection Preventionist, indicated he/she was not aware of the mopping with disinfectant only once a week and indicated the practice had not been approved by the Infection Control Committee. He/she was also unaware of the trial product at the Surgery Extension or how to use it. He/she confirmed the issues with the chemicals and disinfection practices.</p> <p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8(c)(1)</p> <p>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:</p> <p>(1) A mechanism shall be maintained which specifies the delineated</p>				<p>member will be visually monitored monthly for proper chemical use, mixing, use of premeasured stations, and labeling. These monitors will be reported to PIC quarterly. Goal of 95%.</p>		

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	<p>surgical privileges of each practitioner. Based on document review and interview, the hospital failed to ensure policies and procedures (P&amp;P) governing surgical care were in accordance of standards between 11/4/15 and 9/29/15.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the P&amp;P titled Surgery: Temperature and Humidity Check, indicated Temperatures should be maintained in the operating room between 60 degrees F (Fahrenheit) and 75 degrees F, per AORN (Association of periOperative Registered Nurses) Standards. The P&amp;P was approved 11/4/14.</li> <li>2. Review of AORN recommended operating room (OR) temperature ranges indicated The recommended temperature range in an operating room is between 68 degrees F and 75 degrees F. The document was updated 3/2015. Review of 2012 AORN recommendations also indicated recommended OR temperatures is between 68 degrees F and 75 degrees F.</li> <li>3. Review of facility documentation of operating room temperatures between 9/1/15 and 9/25/15 indicated the</li> </ol>	S 2116	<p>During the survey, surveyors found that the hospital failed to ensure policies and procedures governing surgical care were in accordance of standards. 10/1/15 – OR temp increased to 68° F, educated OR staff and Facilities staff as to accepted temperature range. Revised policy to state OR temperatures are to be kept between 68° - 75°F in accordance with AORN Guidelines. All other ORs were reviewed and temperatures were adjusted to meet updated policy. 10/9/15 – Revised policy approved stating OR temperatures are to be kept between 68°-75° F. No clients were affected by OR temperature range. Clients are routinely warmed during OR procedures. OR temperatures are checked and logged daily by OR staff currently and ongoing. OR staff notifies Facilities Services immediately if OR temperatures are not within acceptable temperature range to bring temperatures to acceptable range. OR staff and Facilities staff continue to monitor, document and adjust temperature until it has reached acceptable range. Responsible parties: Director of Surgery or designee The temperature log is checked weekly by the Director of Surgery for compliance to the temperatures stated in the policy. The Director of Facility Services</p>	10/09/2015	

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	<p>following temperatures in degrees F were recorded for OR#1 on the following dates: 9/1, 64; 9/2, 63.4; 9/3, 64; 9/4, 64; 9/8, 63.7; 9/9, 64.4; 9/10, 63.2; 9/11, 63.2; 9/14, 63.2; 9/15, 63.0; 9/16, 63.4; 9/17, 63.5; 9/18, 63.5; 9/21, 63.5; 9/22, 63.0; 9/23, 63.4; 9/24, 63.2; 9/25, 63.2.</p> <p>4. On 9/29/15 at 4:50pm, A12, Director of Surgery, indicated the OR temperatures and P&amp;P were not in agreement with the AORN Standard.</p>				<p>checks the Building Automation System log daily for compliance to the temperatures stated in the policy. OR temperatures are continually monitored by the Building Automation System in Facility Services. OR temperature monitoring is an on-going process. Denominator: Daily OR temperature Numerator: Days OR temperature is within the acceptable temperature range of 68°-75°F. Audit results are reported to the Process Improvement Committee quarterly. Goal of 95%.</p>		