

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150030	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2015
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S 0000 Bldg. 00	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005028</p> <p>Survey Date: 8-24-2015 - 8-26-2015</p> <p>QA: cjl 09/14/15</p> <p>IDR Committee met on 10/19/15; Tag S570 deleted. JL</p>	S 0000		
S 0312 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD</p> <p>410 IAC 15-1.4-1(c)(6)(D)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</p> <p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to conduct, per policy, a performance evaluation for</p>	S 0312	The deficiency was corrected prior to the survey completion. The administrative representative for the contracted employee	08/26/2015

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>1 (PF#2) of 10 employee files reviewed.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled PERFORMANCE APPRAISAL, approved 3-20-2015, indicated each employee must receive a performance review ... annually, and the Department Director [supervisor] will evaluate each employee's performance.</p> <p>2. Review of 10 personnel files indicated file PF#2, a contracted pharmacist, did not contain any documentation of performance evaluation conducted by the facility. The file contained a performance evaluation done by an individual employed by the contractor and did not indicate an authorized individual, supervisor, from the hospital had reviewed and dated the review of the evaluation.</p> <p>3. In interview on 8-25-2015 at 12:30 pm, employee #A7, Human Resources Director, confirmed the evaluation was done by an individual not authorized by the hospital. The employee also confirmed the evaluation did not have documentation that an authorized individual, supervisor, from the hospital had reviewed and dated it.</p>				<p>immediately reviewed the evaluation which was in the contracted employees' file and signed it to verify he had reviewed and accepted the evaluation as written. All contracted employees have been added to the list of evaluations which should be submitted to the Human Resources Department on an annual basis. The Human Resources Department will verify that all evaluations of contracted employees have been reviewed and signed. The signature will indicate acceptance of the evaluation as written. The Human Resources Department Director will be responsible to ensure the protocol above is completed in the future. The deficiency was completed on 8/26/2015.</p>		

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S 0332 Bldg. 00	<p>4. In interview on 8-26-2015 at 12:40 pm, employee #A5, Regulatory Director, indicated the contract between the hospital and the contractor did not authorize the contractor to perform personnel evaluations for the hospital.</p> <p>5. No further documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and interview, the facility failed to ensure that environmental services (EVS) personnel maintained competency documentation for cleaning and disinfecting in the restricted surgical environment for 2 of 2 EVS personnel (EV11, EV12).</p>	S 0332	All environmental service personnel receive competency training on cleaning the restricted surgical area, including terminal cleaning. This training takes place when the employee is hired and again on an annual basis. A copy of an environmental service employee's competency training has been provided as an example	09/20/2015

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	<p>Findings:</p> <p>1. The Association of periOperative Nurses (AORN) Recommended Practices for Environmental Cleaning (2014) indicated the following: "Perioperative and EVS personnel must ...complete competency verification activities that address specialized knowledge and skills related to the principles and processes of environmental cleaning ...Competency assessment measures individual performance, provides a mechanism for documentation, and verifies personnel have an understanding of facility policies ...Process monitoring must be a part of every perioperative setting as part of an overall environmental cleaning program. Process monitoring should include ...cleaning procedures [and] monitoring cleaning and disinfection practices ..."</p> <p>2. On 8-24-15 at 1100 hours, the director of nursing A2 was requested to provide competency documentation for the EVS staff providing services in the restricted surgical environment and none was provided prior to exit.</p> <p>3. The personnel files for EV11 and EV12 failed to indicate documentation of process monitoring observations by a qualified person for the personnel providing services in the operating rooms</p>		<p>(S0332 - Attachment A). The employee is required to watch a movie regarding each specific assessment and then must pass a test regarding the assessment. In the future, the Director of Housekeeping will be responsible to ensure a copy of the initial and annual competency training is kept in each environmental services employees' personnel file. All environmental service personnel who provide services in the restricted surgical area will be observed on an annual basis by the Director of Housekeeping. During the observation, the Director of Housekeeping will complete an observation form (S0332 - Attachment B). The form will be placed in the environmental service employees' personnel file. In addition to the observations by the Director of Housekeeping, the Infection Control Officer will conduct random observations of the environmental service personnel performing disinfection/terminal cleaning of the restricted OR area at least 2 times a year. These observations will be done without the environmental service personnel's knowledge and will utilize housekeeping policies as a checklist for the observations (S0332 - Attachment C and S0332 - Attachment D). The Director of Housekeeping and the Infection Control Officer are both responsible to ensure their respective observations are</p>	

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S 0566 Bldg. 00	<p>(OR) at the facility</p> <p>4. In interview on 8-24-15 at 1525 hours, the environmental services manager A10 confirmed that no documentation of observations by manager A10 of the EVS personnel performing terminal OR cleaning and disinfecting was available.</p> <p>5. In interview on 8-25-15 at 1318 hours, the infection control (IC) nurse A14 confirmed they (A14) had not observed any EVS personnel performing terminal OR cleaning and disinfecting in 2015.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (e)(1)(2)</p> <p>(e) The chief executive officer, medical staff, and executive nurse shall do the following:</p> <p>(1) Be responsible for the implementation of successful corrective action plans in affected problem areas.</p> <p>(2) Provide for appropriate infection control input into plans for renovation and new construction to ensure awareness of federal, state, and local rules that affect infection control practices as well as plan for appropriate protection of patients and employees during construction or</p>		completed and included in the environmental service employees' personnel files.		

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	<p>renovation.</p> <p>Based on document review and interview, the chief executive officer, medical staff, and the executive nurse failed to ensure its handwashing policy was followed and ensure a corrective action was implemented in response to handwashing compliance monitoring reported through the infection control (IC) committee.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Handwashing (approved 1-15) indicated the following: "Hands will be washed before and after contact with each patient ..." 2. The IC committee minutes from 1-28-14 through 7-21-15 indicated quarterly hand hygiene compliance rates ranging from 58% to 72% over 7 quarterly sampling intervals and the IC minutes failed to indicate a committee action in response to the level of handwashing compliance. 3. In interview on 8-25-15 at 1335 hours, the infection control nurse A14 confirmed the minutes failed to indicate a committee response to the level of handwashing compliance reported through the IC meeting minutes. 	S 0566	<p>The week of September 7, the Infection Control Officer met with the Chief Nursing Officer and Director of Quality regarding lack of progress in achieving a hand washing rate of 90%. The current program was evaluated and it was determined changes were needed in order to refocus and increase compliance. The following changes have been implemented in an effort to increase hand washing compliance. The new plan was presented to the Nursing Directors on September 15, 2015. The new plan was presented to all Department Directors on September 18, 2015 at Safety Huddle (S0566 - Attachment A).</p> <ol style="list-style-type: none"> 1. An increase in the number of hand washing observers in each patient unit. The following is a listing of the number of hand washing observers that will be needed on each unit: Progressive Care- 4 (increase by 3 observers) Emergency Department -3 (increase by 2 observers) ICU -2 (increase by 1 observer) Women and Children's Unit - 2 (increase by 1 observer) Surgery - 3 (increase by 1 observer) These observers must be staff members willing to commit to the following: 1 year of observations, perform 8 observations on a monthly basis, attend education on the proper way to perform observations and be familiar with the hand washing 	09/15/2015

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	4. In interview on 8-25-15 at 1530 hours, the director of nursing A2 confirmed the minutes lacked documentation of a corrective action to the identified concern.		forms. The new hand washing observers should be chosen by October 1 and should receive education during the week of October 12 on the updated program and their responsibilities and expectations as observers. Observers may be from (and are encouraged to be from) ancillary departments. Nursing staff has been reminded they can be observed by others outside their department and this does count in your rate, as the patients safety is primarily the responsibility of nursing unit personnel. 2. If an observer turns in the 8 required observations for 2 months in each quarter they will receive a \$25.00 gift card for their participation. 3. The Infection Control Officer will give monthly updates to all staff regarding the hand washing rate at Safety Huddle and CEO Briefing meetings. The rates will be reported as a whole and by individual unit. 4. The Infection Control Officer will also be reporting the hand washing rate on a quarterly basis at the Infection Control Committee Meeting, Medical Review Meetings and MD Service Meetings. The information and any actions taken will be included in the minutes of the meeting. 5. The nursing unit with the highest rate of hand washing for the quarter will be rewarded with their choice of a party: pizza party, dessert party, etc. 6. Hand washing signage has been	

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			placed in all patient units, public restrooms and other areas where staff encounter patients. If the updated action plan does not achieve increased compliance with the World Health Organization's 5 Moments for Hand Washing within a 3 month period (with the final results within 6 months of this new program initiation achieving a rate of 90% or higher), the program will be re-evaluated and new measures will be instituted until the hospital achieves a rate of 90% or higher. Additionally, actions taken by the Infection Control Officer to reflect hand washing program activity efforts will be included in the Infection Control Committee Meeting Minutes beginning with the meeting on October 20, 2015. All actions involving the hand washing effort at Henry County Hospital will be documented in each quarterly meeting minutes of the Infection Control Committee, Medical Review Committee, and Medical Service Meeting. This action will assure that all staff members of Henry County Hospital are aware of the efforts of the hospital and its administrative staff regarding the hand washing effort, the rates, progress toward the hospital goal of 90% and its commitment to patient safety. The Infection Control Officer and Chief Nursing Officer will be responsible to ensure the above action plan is implemented and	

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S 0592 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(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>(i) Sanitation. Based on document review and interview, the infection control (IC) program failed to ensure that the housekeeping services were provided in a safe and effective manner for its isolation patient rooms and for its operating room (OR) suites.</p> <p>Findings:</p> <p>1. On 8-24-15 at 1100 hours, the director of nursing A2 was requested to provide a copy of the occupied infected patient room cleaning policy and none was provided prior to exit.</p> <p>2. In interview on 8-25-15 at 1535 hours,</p>	S 0592	<p>continued.</p> <p>The Daily Patient Room Cleaning Policy was reviewed and updated on September 19, 2015 (S0592 - Attachment A). This policy was in place at the time of the survey. The Daily Operating Room Cleaning Policy was updated in order to indicate an organized terminal OR cleaning process from high to low and clean to soiled including all high-touch surfaces, to indicate the disinfectant which is to be used and the wet contact time, and to indicate the equipment cleaning responsibilities for personnel to ensure all surfaces and equipment are cleaned and disinfected and to minimize the potential contamination of previously cleaned surfaces</p>	09/19/2015
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	<p>the director of nursing A2 confirmed that no facility policy/procedure for occupied infected patient room cleaning was available.</p> <p>3. The Association of periOperative Nurses (AORN) Recommended Practices for Environmental Cleaning (2014) indicated the following: "Cleaning an area in a methodical pattern establishes a routine for cleaning so that items are not missed during the cleaning process. The method for cleaning may limit the transmission of microorganisms to reduce the risk of cross contamination of environmental surfaces ...Cleaning should progress from clean to dirty areas. Cleaning should progress from top to bottom areas ...Cleaning of high-touch objects after each patient use should include cleaning of any soiled surface of the item and any frequently touched areas of the item (control panel, switches, knobs, work area, handles) ... Disinfectants should be applied, and reapplied as needed, per manufacturers' instructions, for the dwell time required to kill the targeted microorganism ...spray and misting methods (eg, a spray bottle) should not be used to apply cleaning chemicals in the perioperative practice setting ...used cleaning materials (eg, mop heads, cloths) should not be returned to the cleaning solution container."</p>		(S0592 - Attachment B). All environmental service staff attended an in-service on September 9, 2015 regarding Terminal OR cleaning processes (S0592 - Attachment C). It is the responsibility of the Director or Housekeeping and Infection Control Officer to ensure the hospital's policies and procedures for the occupied patient room and terminal OR cleaning are current and in compliance recommended practices.	

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	<p>4. The Housekeeping policy/procedure Daily Operating Room Cleaning (approved 10-12) indicated the following: "Germicide solution will be used for all damp dusting and wall washing in the operating room and surrounding areas. Fresh solution will be prepared and clean cloths or sponge frequently rinsed in the solution." The policy/procedure failed to indicate an organized process for OR cleaning or including the principles for cleaning from clean to dirty and from top to bottom areas to minimize the contamination of previously disinfected surfaces and failed to indicate a requirement for cleaning all high-touch objects and surfaces. The policy/procedure failed to ensure cleaning cloths were not returned to the disinfecting solution after initial wetting, failed to indicate the minimum wet contact time for disinfecting products used by operating room staff and environmental services (EVS) personnel, and failed to indicate OR equipment cleaning responsibilities for both personnel.</p> <p>5. In interview on 8-25-15 at 1230 hours, the infection control nurse A14 confirmed that the policy/procedure failed to indicate an organized terminal OR cleaning process from high to low</p>			

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S 0952 Bldg. 00	<p>and clean to soiled including all high-touch surfaces, failed to indicate the disinfectant to be used including wet contact times, and failed to indicate the equipment cleaning responsibilities for personnel to ensure all surfaces and equipment are cleaned and disinfected and to minimize the potential contamination of previously-cleaned surfaces.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on document review and staff interview, the facility failed to follow approved medical staff policies and procedures for the administration of 1 of 7 transfusions reviewed.</p> <p>Findings include: 1. A policy titled "4.8 ADMINISTRATION OF BLOOD" which stated under "GENERAL INFORMATION/KEY POINTS: 17.</p>	S 0952	All licensed nursing staff participate in an annual Blood Competency. This competency includes the information regarding the maximum length of time a transfusion is to run over (4 hours). Any time the four hour maximum limit is exceeded and the transfusion is not discontinued, the blood bank reports the breach in protocol to the director of the nursing department where the breach occurred. The department	09/16/2015

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S 1172 Bldg. 00	<p>Blood must be infused within 4 hours. At 4 hours if transfusion is not complete it must be discontinued."</p> <p>2. Review of Transfusion number T-CP#1 revealed:</p> <ul style="list-style-type: none"> a. it was removed from refrigeration at 12:22 p.m. b. the transfusion was stopped at 12:51 p.m. to investigate possible reaction, c. Restarted at 13:58 p.m. d. Completed at 16:50 p.m. and was not stopped at 4 hours but continued to infuse 28 minutes past the 4 hour deadline from the time of removal from refrigeration. <p>3. SP (Staff Person)#1 acknowledged on 8/25/15 at 10:40 a.m. the 4 hour time limit for blood infusion had not been met for transfusion T-CP#1.</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</p>		<p>director refers the nurse who was involved to Staff Development and the nurse is required to participate in "Blood School" - a class which educates staff on blood products and blood transfusion policies and procedures. The nurse who breached protocol in the example reviewed during the survey was educated at Blood School regarding transfusion policies and protocols. In the future, all licensed nursing staff will continue to be required to complete the annual blood competency and attend "Blood School" in Staff Development any time a breach in protocol occurs. The Chief Nursing Officer, the Nursing Department Directors, and the Staff Development Director are responsible to ensure the nursing personnel is appropriately educated regarding the hospital's blood transfusion policies and protocols. This deficiency was corrected on 9/16/2015.</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>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 observation and interview, the environmental services failed to ensure that all areas were kept clean and ventilation grilles and diffusers were free of dust at the facility.</p> <p>Findings:</p> <p>1. During an observation on 8-25-13 at 1035 hours, the following condition was observed in room 202 of the medical surgical nursing unit: a 24" x 24" ceiling ventilation grille with a significant accumulation of dust and particulate material located directly over the patient bed.</p> <p>2. In interview on 8-25-15 at 1035 hours, the medical surgical manager A11 and director of nursing A2 confirmed that the accumulated dust on the ceiling grille was unsanitary.</p> <p>3. During an observation on 8-25-15 at 1145 hours, the following condition was observed in the newborn nursery room of the obstetrics and pediatrics nursing unit:</p>	S 1172	<p>High dusting of vents is to be completed on a weekly basis by environmental services staff. This is stated in the Daily Patient Room Cleaning Procedures (S1172 - Attachment A). The procedure for High Dusting is included in Housekeeping Services Procedure book (S1172 - Attachment B). All environmental services staff will be re-educated on the high dusting procedures prior to Friday, September 22, 2015. The Infection Control Officer and Director of Housekeeping will spot check to ensure high dusting is completed in all patient areas on a weekly basis. The Director of Housekeeping is responsible to ensure all environmental services staff is re-educated on high dusting and to ensure compliance with the high dusting policy and procedure.</p>	09/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150030	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/26/2015
NAME OF PROVIDER OR SUPPLIER HENRY COUNTY MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362		
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	<p>a 24" x 24" ceiling ventilation diffuser with a significant accumulation of dust and particulate material on the upper horizontal surfaces.</p> <p>4. In interview on 8-25-15 at 1145 hours, the unit manager and director of nursing A2 confirmed that the accumulated dust on the ceiling diffuser was unsanitary.</p>				