

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
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NAME OF PROVIDER OR SUPPLIER INDIANA ORTHOPAEDIC HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8400 NORTHWEST BLVD INDIANAPOLIS, IN 46278
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 003930</p> <p>Survey Date: 2-17/20-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 02/26/14</p>	S000000		

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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S000330	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable. Based on document review and interview, the facility failed to document a post offer physical for 3 of 9 employee files reviewed.</p> <p>Findings:</p> <p>1. Review of hospital PolicyStat ID: 374476, last revised 06/2013, indicated all potential IOH employees and contracted services staff will be required to complete and satisfactorily pass a Post-offer physical.</p> <p>2. Review of 9 employee and contracted services staff personnel files indicated</p>	S000330	A complete audit of all IOH contracted services staff personnel files will be completed by 3/14/2014. Any employee files missing documentation of a post offer physical exam will be identified. The required documentation will be requested of the contracted service provider. If documentation cannot be retrieved, IOH will require the contracted services staff to complete a post offer physical exam by 3/20/2014. To ensure future compliance, a performance improvement process of the on-boarding process for IOH Employees and Contracted services staff will be completed. The Human	03/20/2014			

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S000554	<p>files #P1, #P2, and #P4 did not have any documentation of a post offer physical.</p> <p>3. In interview, on 2-19-14 at 2:30 pm, employee #A3 confirmed the above and no further documentation was provided prior to exit.</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 facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients for 2 of 3 sterile supply storage rooms, 1 procedure room and 1 offsite Physical Therapy department.</p> <p>Findings include:</p> <p>1. Review of the 2001 edition of the national "Guideline for Construction and Equipment of Hospital and Medical Facilities" indicated the following: "7.28.B8. Ceiling finishes in semi-restricted areas such as clean corridors, central sterile supply spaces,</p>	S000554	<p>Resources Director will be responsible for ensuring the employee files are complete per policy and for communicating with all contracted services vendors regarding this process.</p> <p>Items 1-5-In order to meet Infection Control requirements, clipped Armstrong 898b clean room tiles were ordered and received. Infection Control Risk Assessments (ICRAs) were completed 3/03/2014. Installation of the new tiles will be completed on 3/14/2014 at South and 3/15/2014 at West. Plant Operations Managers at both sites are responsible to see the installation is completed. Items 6-7-It is the policy of the hospital that food and drinks are never permitted in the OR. The Surgical Services Director and Infection Control Preventionist will conduct staff education the week of 3/10/2014. To ensure staff follows policy, a member of the</p>	03/24/2014

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	<p>specialized radiographic rooms, and minor surgical procedure rooms must be smooth, scrubbable, non-absorptive, non-perforated, capable of withstanding cleaning with chemicals, and without crevices that can harbor mold and bacterial growth. If lay-in-ceiling is provided, it shall be gasketed or clipped down to prevent the passage of particles from the cavity above the ceiling plane into the semi-restricted environment. Perforated, tegular, serrated cut, or highly textured tiles are not acceptable."</p> <p>2. On 02-18-14 at 0915 hours, the following was observed at the South offsite in the room labeled Bulk Supply: the room contained sterile supplies on the storage shelves and the ceiling was a lay in ceiling type with a non smooth surface and the appearance of holes. Staff #45 was able to raise the ceiling tile with a mop handle.</p> <p>3. On 02-18-14 at 0915 hours, staff #45 confirmed the facility was built around 2006.</p> <p>4. On 02-18-14 at 1145 hours, the following was observed at the West offsite in the sterile supply room: the room contained sterile supplies on the storage shelves and the ceiling was a lay in ceiling type with a non smooth</p>		<p>management team will be responsible to complete random monthly observation audits. Item 8-9-It is the policy of the hospital that any item that comes in contact with a patient will be disinfected before being used on another patient. The Physical Therapy Director will conduct staff education by 3/14/2014. The physical therapy department has switched from Cavicide spray/towel to Cavicide wipes. The Physical Therapy Director or on-site Senior PT staff will member conduct monthly random audits for compliance to policy.</p>				

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	<p>surface and the appearance of holes.</p> <p>5. On 02-18-14 at 1145 hours staff #46 confirmed the facility was built around 2006.</p> <p>6. On 02-17-14 at 1100 hours during the tour of the Surgery area, the following was observed in the procedure room: 1 container of hot brown liquid, 1 bottle of drinking water and 1 plate of cut fruit.</p> <p>7. On 02-17-14 at 1100 hours, staff #43 confirmed that the drinks and food should not be in the procedure room.</p> <p>8. Review of hospital PolicyStat ID: 293986, last revised 10/2012, indicted any item that comes in contact with a patient will be disinfected before being used on another patient.</p> <p>9. On 2-18-14 at 10:30 am, in the presence of employee #A2, it was observed in the Indiana Orthopaedic Hospital West offsite Physical Therapy department, there were 2 patients who had completed their treatment. It was also observed 2 physical therapy staff each, cleaned the just-vacated patient treatment table using only a clean towel. Neither staff used any disinfectant on the table or towel.</p>			

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation and interview, the facility failed to ensure that staff follow policy / procedures and manufacturer's recommendations for the cleaning process of surgical instruments and cleaning equipment.</p> <p>Findings include:</p> <p>1. Review of policy / procedure Care and Cleaning of Surgical Instruments and Power Equipment indicated the following: "E. Decontamination Process: 2. Manual cleaning will be accomplished by submerging the</p>	S000596	It is the policy of the hospital that manual cleaning of surgical instruments and power equipment be done by submerging the instrument in water with an appropriate detergent followed by complete submersion in rinse solution in accordance with manufacturer recommendation. The Surgical Services Director will conduct staff education the week of 3/17/2014. All sinks have been taped at appropriate volume line for water and signage has been posted in appropriate areas to reinforce education and appropriate ratio of cleaner to water. Random audits will be done on a monthly basis by a member of the management team to	03/17/2014			

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	<p>instrument in water with an appropriate detergent followed by complete submersion of the instrument in rinse solution to minimize aerosolization of contaminants."</p> <p>This policy / procedure was last reviewed / revised on 08/2012.</p> <p>2. Review of the manufacturer's recommendations for the Proclean enzymatic cleaner indicated the following: use 0.25 - 2 ounces of enzymatic solution per gallon of water.</p> <p>3. On 02-17-14 at 1230 hours, staff #47 confirmed that he/she uses 1 pump of Proclean enzymatic cleaner to 6 gallons of water.</p> <p>4. On 02-17-14 at 1230 hours, 1 pump of Proclean enzymatic cleaner was measured to be 1 ounce.</p> <p>5. On 02-18-14 at 1130 hours, staff #48 confirmed that he/she uses 2 pumps of Proclean enzymatic cleaner to about 8 gallons of water. Staff #48 indicated to a spot in the sink where 8 gallon mark would be. When 8 gallons of water was placed in the sink, the water did not reach the identified mark.</p> <p>6. Review of the manufacturer's</p>		ensure policy compliance.				

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	<p>recommendations for cleaning brushes indicated the following: "They can be used several times as long as the brush bristles are firm enough to clean the instrument and the brush has been cleaned and decontaminated, at a minimum daily, prior to reuse."</p> <p>7. On 02-17-14 at 1230 hours staff #47 confirmed that he/she may use cleaning brushes for more than 1 dirty instrument set cleanings and will disinfect brushes at the end of the day.</p> <p>8. On 02-18-14 at 1025 hours staff #49 confirmed that he/she may use cleaning brushes for more than 1 dirty instrument set cleanings and will disinfect brushes at the end of the day.</p>				

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S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on document review, observation and interview, the facility failed to ensure that surgical staff followed established policy / procedures for proper dress requirements in 1 instance.</p> <p>Findings include:</p> <p>1. Review of policy / procedure Dress Requirements Within the Surgical Environment indicated the following: "I. Masks must be changed following each surgical procedure." This policy / procedure was last reviewed / revised on 01/2014</p> <p>2. On 02-17-14 at 1130 hours, a patient was brought out of OR #8 and 1 person</p>	S000608	It is the policy of the hospital that surgical masks must be changed following each surgical procedure. The Surgical Services Director will conduct staff education and physician communication the week of 3/10/2014. Random monthly audits will be done by a member of the management team to ensure policy compliance.	03/14/2014	

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S001020	<p>with a surgical mask on covering the mouth and nose and 1 person with a surgical mask hanging around the neck left OR #8, then placed surgical mask over mouth and nose. Immediately, both surgical staff members entered OR #6 where another surgical procedure was currently taking place.</p> <p>3. On 02-17-14 at 1135 hours, staff #43 confirmed that surgical masks should be changed between surgical procedures.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on observation and interview, the hospital failed to ensure the monthly inspection of 1 area where drugs were stored.</p> <p>Findings:</p> <p>1. On 2-17-14 at 3:45 pm, in the</p>	S001020	Hospital policy Floor Stock has been revised to include those pharmacy items stored in Materials Management and will be approved by the Medical Executive Committee on 3/19/2014 and IOH Members Committee on 3/26/2014. After review of Hospital Policy Pharmacy Quality Control-Drug	05/28/2014			

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	<p>presence of employee #A2, it was observed in the Storeroom of the main hospital there were the following stored on shelves:</p> <p>48 boxes Simplex P with Tobramycin 1g bone cement 10 boxes DePuy GHV SmartSet Gentamicin 1m.i.u (40g) bone cement</p> <p>2. Review of the hospital's formulary indicated Tobramycin and Gentamicin, both antibiotics, were included in the formulary.</p> <p>3. In interview, on 2-19-14 at 12:20 pm, employee #A4, when asked to provide documentation of monthly pharmacy inspection reports for the bone cements with antibiotic, indicated there were no reports and no further documentation was provided prior to exit.</p>		<p>Storage Areas-Monthly Inspections the policy already addresses oversight of all medication by the Pharmacy Department and requires authorized personnel to complete monthly inspections which are reviewed by the Pharmacy Director. The pharmacy is now providing oversight of items in Materials Management per policy. Effective immediately, monthly inspections will begin in Materials Management and will be reviewed by Pharmacy Director per policy. The formulary has been revised to include all pharmacy items stored in Materials Management. The updated formulary will be presented for approval by the Pharmacy and Therapeutic Committee 4/01/2014, then Medical Executive Committee on 4/16/2014 and the IOH Members Meeting on 5/28/2014.</p>		

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S001150	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.</p> <p>Findings:</p> <p>1. On 2-17-14 at 4:10 pm in the presence of employee #A5, it was observed in the Environmental Services Storage Room of the main hospital, there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S001150	The Plant Operations Manager placed an integrated backflow preventer on the referenced faucet, converting it to a backflow faucet on 3/06/2014. The Plant Operations Manager will monitor compliance with the Indiana Plumbing Code as a part of the monthly Plant Operations inspections.	03/06/2014	