

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151316	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2012
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NAME OF PROVIDER OR SUPPLIER ST VINCENT FRANKFORT HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 S JACKSON ST FRANKFORT, IN 46041
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 10/31/2012 through 11/1/2012</p> <p>Facility Number: 005039</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 11/16/12</p>	S0000		

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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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review, the facility failed to ensure 2 services (Laundry/Linen and Housekeeping) provided by contractors were included in its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. St. Vincent Frankfort Hospital Performance Improvement and Patient Safety Plan implements each clinical, non-clinical, and medical staff department/service is involved in the improvement of organizational performance. Each</p>	S0406	<p>1.) Laundry/linen service department added to PCRC scorecards. Housekeeping was previously measured as part of the Dietary/Housekeeping scorecard so that will be separated out as its own scorecard. Measures will be audited and assessed monthly and reported to Performance Improvement committee on a quarterly basis. 2.) To maintain compliance with state measure, laundry/linen quality scorecard will be added to PCRC standing agenda items for each quarterly PCRC meeting.3.) Enviromental service manager to be responsible for auditing and completing launcry/linen quality scorecard.4.) An annual site visit will be scheduled to evaluate the quality standards at vendor's site. Manager and Infection Preventionist will attend.5.)</p>	11/30/2012

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	<p>department is responsible for monitoring the performance of services provided within its structure.</p> <p>2. The 2011 and 2012 Performance Improvement and Patient Safety Committee minutes were reviewed. The minutes and the data did not evidence the contracted services of Laundry/Linen and Housekeeping were being evaluated.</p> <p>3. At 3:40 PM on 11/1/2012, staff member #1 confirmed the two contracted services were not being evaluated by the hospital's Performance Improvement and Patient Safety Committee.</p>		<p>Housekeeping staff will conduct weekly linen checks of 5 bundles of linens per week to ensure linen is free of stains, holes, and generalized dirt. Failures will be reported to the housekeeping manager and through the PCRC committee. Linen shortages will be reported as well.5.) Deficiency corrected 11/30/12.ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for this Plan of Correction.</p>		

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S0554	<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. Based on policy review, observation, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p> <p>Findings included:</p> <p>1. The facility policy "Crash Cart Integrity for Adult, Neonatal and Pediatric", last revised 12/2010, indicated, "...5. The contents and expiration dates of all items in the crash bag shall be checked, at a minimum, monthly, and after each use of the bag. This check should be recorded on the Crash Bag Inventory Log. The responsibility for this monthly check will be assigned by the Unit Supervisor and rotated throughout the staff nurses."</p> <p>2. During the tour of the 2 South Med/Surg Unit at 11:20 AM on 10/31/12, accompanied by staff members #A1, the following items were observed in the crash cart: A. One of three lavender top lab tubes expired 09/2012. B. Two of two Pedi-cap CO2 detectors, one expired 08/2012 and one expired 09/2012. C. One of one 500 milliliter bag of sterile water expired 1 Aug. 2012.</p> <p>3. While still on the 2 South Med/Surg Unit at 12:05 PM on 10/31/12, accompanied by staff members #A and A2, the following items were</p>	S0554	<p>1.) All expired IV fluids, medications, and lab tubes removed from service day of survey and discovery from all refrigerators, medication rooms, supply carts, and pediatric and adult crash carts.2.) Crash cart integrity checks to be completed monthly and after use of each bag/cart in all departments. Outdates of supplies, meds, and lab tubes to be assessed monthly. Items expired are to be removed from cart/bag immediately upon discovery. 3.) Department managers to add crash cart outdates to PCRC quality scorecard and report quarterly. Quality improvement department to audit compliance with crash cart integrity checks monthly for 6 months. Quality Manager will determine after the initial 6 months if an additional 6 months of monitoring is required based on compliance.4.) Deficiency to be corrected 11/30/12.ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for</p>	11/30/2012			

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	<p>observed in the Pediatric Emergency Black Bag:</p> <p>A. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the yellow sleeve.</p> <p>B. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the green sleeve.</p> <p>C. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the orange sleeve.</p> <p>D. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the white sleeve.</p> <p>E. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the blue sleeve.</p> <p>F. One of one Pediatric Ambu-laryngeal mask expired 07/2011.</p> <p>G. Six of seven Infant 25% Dextrose Injection expired 1 Oct. 2012.</p> <p>4. At 12:15 on 10/31/12, accompanied by staff members #A1 and A2, the following items were observed in the cabinet in the old medication room of the nurses' station of the 2 South Med/Surg Unit:</p> <p>A. Eight of eight BBL Culture Swab tubes with medium, four expired 03/2009, one expired 09/2010, two expired 02/2011, and one expired 04/2011.</p> <p>5. At 12:15 PM on 10/31/12, staff member #A2 indicated there was no record of monthly checks of the emergency supplies.</p> <p>6. During the tour of the Obstetrical Department at 12:30 PM on 10/31/12, accompanied by staff members #A1 and A10, the following items were observed in the 2 supply carts in the nursery:</p> <p>A. One of four Povidone Iodine swabs expired 04/2010.</p>		this Plan of Correction.				

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	<p>B. One of one 20 milliliter vial of 0.9% sodium chloride expired 1 June 2012.</p> <p>C. Three of three 20 milliliter vial of 0.9% sodium chloride expired 1 August 2012.</p> <p>D. Two of two green cap mini lab tubes with medium expired 10/2011.</p> <p>E. Two of two lavender cap mini lab tubes with medium expired 04/2012.</p> <p>F. Two of two red cap mini lab tubes with medium expired 10/2011.</p> <p>G. Two of two blue cap mini lab tubes with medium expired 09/2011.</p> <p>7. During the tour of the Surgery Department at 1:50 PM on 10/31/12, accompanied by staff members #A1 and A11, nine of nine 50 milliliter vials of sterile water with an expiration date of 1 Oct. 2012 were observed in the OR storage room refrigerator. Staff member #A11 indicated he/she didn't know how they were missed because he/she and the staff were very conscientious about outdates.</p>			

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S0610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure high-protein nutrition tube supplements were stored properly in the Material Handling Department.</p>	S0610	<p>1.)Pedialyte and Similac found stored under lights in material handling department were removed the date of survey from service. 2.) All light sensitive nutrients will be stored in closed containers in the material handling department until they are used or are placed in closed cabinets for the different areas of service. 3.) Materials will add monitoring of this product to their</p>	11/01/2012	

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	<p>Findings included:</p> <ol style="list-style-type: none"> At 1:05 PM on 10/31/2012, the Material Handling Department was toured. A storage rack containing 52 Similac Advance and 64 Pedialyte were observed removed from their cases and were placed on the shelves of the storage rack. Above the storage racks and other locations throughout the dry storage room were 4-bulb ceiling mounted fluorescent light fixtures. The manufacturer's label of Similac and Pedialyte high-protein nutrition states, "Contains light-sensitive nutrients." At 1:15 PM on 10/31/2012, staff member #1 confirmed the label of the tube feeding nutrients were light sensitive and the tube feeding supplements were stored on a shelf exposed to bright lights in the Material Handling Department. 		<p>PCRC scorecard.4.) Quality Improvement to spot check material handling storeroom for compliance with storing light sensitive nutrients on a monthly basis for period of 6 months and to report to PCRC committee quarterly. Quality manager will determine at the end of the initial 6 months if additional monitoring is deemed necessary based on a compliance rate < 100%.5.) Deficiency corrected 11/1/12.ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for this Plan of Correction.</p>		

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S0744	<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 medical record review and interview, the facility failed to ensure all forms were accurate and completely filled out for 10 of 14 closed patient records reviewed (#N1, N3, N5, N6, N7, N8, N9, N10, N12, and N14).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Emergency Physician Record from 04/01/12 for patient #N1 lacked documentation by the physician of a "Condition on Disposition" from the ER. The Discharge Teaching Summary from 05/24/12 for patient #N3 lacked documentation of follow-up care in the spaces provided. The Emergency Physician Record from 04/16/12 for patient #N5 indicated the disposition from the ER was to home when the patient was actually admitted to the hospital. The Emergency Physician Record from 08/02/12 for patient #N6 lacked documentation by the physician of a time for the disposition from the ER. Also, the "Consent: Information- Records-Treatment- Financial Responsibility" was totally blank. The Emergency Physician Record from 07/13/12 for patient #N7 lacked documentation by the physician of a time for the disposition from the ER. 	S0744	<p>1) ER manager to reeducate physicians of componets of complete medical record. Condition on disposition and time of disposition to be completed on all ER patients. Correct disposition to be documented by ER physician. Email instructions sent to those physicians who are not currently on the schedule. A) Condition on dispostion and time of discharge added to the emergency room performance improvement scorecard. (See attached scorecard) 30 charts will be audited and reported to ERPI committe monthly for a minimum of 12 months. B) Quality improvement department to monitor standard compliance and report to ER manager and ER medical director on monthly basis. Quality Manager will determine the need for further evaluation at the end of the 12 month period based on increased/decreased compliance.ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for</p>	11/30/2012	

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	<p>6. The Emergency Physician Record from 02/29/12 for patient #N8 lacked documentation by the physician of a time for the disposition from the ER.</p> <p>7. The Emergency Physician Record from 02/18/12 for patient #N9 lacked documentation by the physician of a "Condition on Disposition" from the ER, a time, and that the patient was admitted. Also, the "Multidisciplinary Care Team Patient Needs/Problems and Teaching" form lacked documentation of dates identified and dates resolved for any problems identified.</p> <p>8. The Emergency Physician Record from 07/13/12 for patient #N10 lacked documentation by the physician of a time for the disposition from the ER.</p> <p>9. The Emergency Physician Record from 07/13/12 for patient #N12 lacked documentation by the physician of a time for the disposition from the ER.</p> <p>10. The "Consent: Information- Records- Treatment- Financial Responsibility" was totally blank for patient #N14, an infant born 03/30/12.</p> <p>11. At 3:00 PM on 11/01/12, staff members #A2 and A19, who navigated the Electronic Medical Records (EMR), confirmed the medical record findings. Also, staff member #A1 indicated the infant should have a consent form signed.</p>		this Plan of Correction.		

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on policy and procedure review, observation, and interview, the facility failed to ensure a safe environment for patients by following their policy regarding warmed fluids in the Obstetrical and Surgery Departments.</p> <p>Findings included:</p> <p>1. The facility policy "Warmed IV Fluids and Irrigation Solutions Storage", approved December 15, 2011, indicated, "...A. IV fluids within their plastic overwrap and bottles of irrigation solution may be placed in a fluid warmer to be warmed to a maximum temperature of 104 degrees Fahrenheit (40 degrees Celsius). 1. Fluids may be stored in the warmer for a maximum of 14 days. ...5. The IV bag or bottle or irrigation fluid must be labeled with the following information: a. Date placed in warmer. b. Date bag should be removed from warmer. c. Expiration date."</p> <p>2. During the tour of the Obstetrical Department at 12:45 PM on 10/31/12, accompanied by staff members #A1 and A10, a warming unit was observed in the nurses' station. The bottom portion of the unit contained three 1500 milliliter</p>	S1118	The policy titled "Warmed IV Fluids and Irrigation Solutions Storage" has been changed to include information regarding the Temperature Recorders and Logs for the Warmers. Warmer logs have been established for all warmers with a range requirement of 104 degrees or below. In departments that are staffed 24/7, all warmers are to be checked daily and the temperatures logged. Any report of temperature 105 degrees or greater will be addressed with Plant Maintenance and all fluids will be removed until temperature falls within required range. Once removed, fluid will be redated as per policy guidelines. Those departments that are not staffed 24/7 will check the Temperature Recorder upon reopening to ensure that the Temperature has not exceeded 104 degrees. If at any time the Temperature did exceed 104 degrees, all fluids will	11/30/2012			

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	<p>bottles of sterile water, dated 11/9, 11/9, and 11/13, a tube of ultrasonic gel, and some infant shirts and the temperature dial registered 115 degrees Fahrenheit (F). The top portion contained blankets only. Staff member #A10 indicated he/she was unsure of the correct temperature, but indicated it was under 120 degrees F. He/she indicated the dates on the solution identified the expiration dates of the bottles. He/she also indicated there were no temperature monitoring logs for the warmer.</p> <p>3. During the tour of the Surgical Department at 1:05 PM on 10/31/12, accompanied by staff members #A1 and A11, an Amsco warmer was observed in the OR hallway. The top portion contained blankets and a bottle of lotion and the bottom portion contained IV and irrigation fluids. Staff member #A11 indicated the fluids were dated when they were placed in the warmer and staff knew they had a 14 day use. He/she indicated the warmer was monitored Monday through Friday and the temperature range was 105- 110 degrees F. with the standard being 108 degrees F. He/she indicated the temperature standard was provided by the fluid manufacturer, but did not have any documentation of this. The October 2012 temperature log indicated 3 days registered 106 degrees F., 8 days registered 107 degrees F., 6 days registered 108 degrees F., and 5 days registered 109 degrees F.</p> <p>4. At 11:00 AM on 11/01/12, staff member #A1 indicated he/she could not provide temperature range documentation from the fluid manufacturer and confirmed the units were not following the facility policy regarding dating and monitoring the fluids in the warmers.</p>		<p>be removed and redated as per policy. New Labels were created to include the date fluid was placed in the warmer, date fluid must be removed (14 days past initial date), and the new expiration date once the fluids have been warmed. Quality Manager will audit log completion for Surgery and OB warmers for 6 months. Surgery and OB managers have placed the Warmer logs on their PCRC monthly reportcards. After the initial 6 months, the Quality Manager will determine if further auditing is necessary based on compliance less than 100%. ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for this Plan of Correction.</p>				

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S1164	<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.</p> <p>Based on document review and staff interview, the facility failed to daily record the hydrocollator temperatures as per hospital policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. St. Vincent Frankfort Hospital's Physical Therapy Department Safety policy; last reviewed March 2011, specifies the department's hydrocollator to record daily hot pack temperature checks. 2. The Hydrocollator Temperature Logs were reviewed between for the first 10 months of 2012 and the temperature logs revealed 21% of the daily temperature checks were 	S1164	<p>1.) Temperature log on hydrocollator to be completed daily Monday-Friday by physical therapy staff. Director delegated responsibility to staff member who is in the department on regular M-F basis. Any out of ranges temps are to be reported to the director of PT.2.) PT manager to review log for completion and report monthly on PCRC scorecard and reported quarterly to committee. Quality improvement to audit completion rate of hydrocollator log monthly for 12 months to insure compliance with standard. Quality Manager will determine after the initial 12 months if an additional 6 months of monitoring is required based on compliance.3.) Deficiency corrected 11/30/12.ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for</p>	11/30/2012	

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	<p>completed: January 5 of 31 days; February 1 of 29 days; March 7 of 31 days; April 9 of 30 days; May 10 of 31 days; June 9 of 30 days; July 11 of 31 days; August 11 of 31 days; September 2 of 30 days; and 9 of 31 days.</p> <p>3. At 3:45 PM on 11/1/2012, staff member #12 indicated he/she was only at the hospital once a week and he/she was the only one responsible to record the hydrocollator daily temperatures. The staff member confirmed the data that was provided was accurate and the data revealed the temperatures of the hydrocollator were not being recorded as required by policy.</p>		this Plan of Correction.		

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, interview, manufacturer's directions, and policy and procedure review, the facility failed to ensure the defibrillator checks were performed according to policy and manufacturer's instructions.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During the tour of the 2 South Med/Surg Unit at 11:20 AM on 10/31/12, accompanied by staff member #A2, A Zoll M defibrillator was observed on the crash cart with a log of daily checks for October 2012. Staff member #A2 indicated the defibrillator is checked and discharged daily, usually on the night shift. 2. During the tour of the Obstetrical Department at 12:20 PM on 10/31/12, accompanied by staff members #A1 and A10, A Zoll M defibrillator was observed on the crash cart with a log of daily checks for October 2012. Staff member #A10 indicated the defibrillator is checked and discharged daily. 3. During the tour of the Surgical Department at 1:15 PM on 10/31/12, accompanied by staff members #A1 and A11, A Zoll M defibrillator was observed on the crash cart with a log of Monday through Friday checks for October 2012. Staff 	S1168	<p>All nursing departments that are staffed 24/7 will conduct defibrillator checks every 12 hours per manufacturer's recommendations. Within the Surgery department the defibrillator in the PACU will be checked daily M-F between 7am -3pm as the PACU is not opened for emergent cases. The defibrillator in the OR however, can be used for emergent after-hours cases, therefore the House Supervisors will check it for the night shift M-F and for both day and night shift on Sat-Sun. Quality Manager will audit the defibrillator logs for 6 months and determine at that time if additional monitoring is needed based on compliance <100%. All department Managers should have defibrillator log placed on PCRC scorecard. ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for this Plan of Correction.</p>	11/30/2012	

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	<p>member #A11 indicated the defibrillator is checked and discharged daily when the surgery department is open. He/she confirmed that emergency surgery or cesarean sections might be performed during the night or on week-ends.</p> <p>4. During the tour of the Emergency Department at 9:25 AM on 11/01/12, accompanied by staff members #A1 and A20, A Zoll M defibrillator was observed on the crash cart with a log of daily checks for October 2012. Staff member #A20 indicated all of the defibrillators are checked and discharged daily.</p> <p>5. The manufacturer's directions for the Zoll M Series defibrillator indicated, "...Resuscitation equipment must be maintained to be ready for immediate use. The following operational checks should be performed at the beginning of every shift to ensure proper equipment operation and patient safety." The instructions continued with a list of all the checks to be performed including checking all of the supplies and discharging the unit.</p> <p>6. The facility policy "Crash Cart Integrity for Adult, Neonatal and Pediatric", approved 12/2010, indicated, "...3. c. Check your defibrillator at the manufacturer's suggested joules each shift (on Crash Carts)."</p> <p>7. At 2:15 PM on 10/31/12, staff member #A1 confirmed the defibrillators were not being checked each shift and that emergency surgeries or cesarean sections might be performed during nonroutine OR times.</p>				

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S1172	<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 interview, product information, and training records, the facility failed to provide environmental services to ensure safe infection control practices throughout the facility.</p> <p>Findings included:</p> <p>1. At 9:20 AM on 11/01/12, environmental staff member #A21 was interviewed in the emergency department. He/she indicated Alpha-HP multi-surface cleaner was used in a bucket of solution to wipe all surfaces and patient carts in the emergency department, then he/she waited for 3 to 5 minutes before remaking the carts. He/she indicated this same cleaner was used in the buckets to mop the floors. He/she indicated Crew M was used in the bathrooms and either Dispatch or Expose 256 was used for any blood or body fluid areas. He/she indicated the wait time for the Expose 256 was 5 minutes, but the manufacturer's</p>	S1172	Alpha HP multi-surface cleaner was replaced with Alpha HP Disinfectant which is now used hospital-wide for routine cleaning. Inservice were conducted for all housekeeping staff describing the specifications from the manufacturer and that the Alpha HP Disinfectant should be used for all routine cleaning throughout the hospital. Also educated on use of Expose II 256 Phenolic Disinfectant Cleanser for MRSA and Dispatch Wipes for areas exposed to C-difficile. MSDS sheets were also reviewed with staff to explain how to know what a product is made of and how to determine its effectiveness on organisms. There was an inservice on	11/09/2012			

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	<p>label indicated the kill time was 10 minutes. Staff member #A21 indicated he/she had worked here for 3 years.</p> <p>2. At 10:00 AM on 11/01/12, the Infection Preventionist, staff member #A13, indicated the environmental services were provided by a contracted service who supplied their own chemicals. He/she indicated he/she provided generic training regarding C-diff and terminal cleaning, but not specific to any chemicals. He/she indicated MSDS (Material Safety Data Sheets) for the various chemicals were provided by the company, but they did not address organism effectiveness or instructions for use.</p> <p>3. At 10:30 AM on 11/01/12, the supervisor of the contracted service, staff member #A5, provided product information for the various chemicals used. The literature for Alpha-HP multi-surface cleaner indicated, "An all-in-one, multi-purpose cleaner concentrate based on proprietary Accelerated Hydrogen Peroxide (AHP) technology. ...Blends commonly used chemicals with low levels of hydrogen peroxide for high productive cleaning. Use on all washable surfaces. Multiple dilution rates. Use as a carpet prespray or carpet extraction cleaner." The literature lacked any information regarding effectiveness against organisms or any disinfectant properties. Staff member #A5 indicated the new company took over in March 2012 and all employees were educated regarding new chemicals. He/she indicated two employees had allergic reactions to one of the chemicals and he/she called the company and was told the Alpha-HP cleaner could take the place of the one they were using. He/she agreed the product was a cleaner and not a disinfectant.</p> <p>At 4:30 PM on 11/01/12 during the exit</p>		<p>11/7/2012 for the nightshift and one on 11/9/2012 for the dayshift. All housekeeping staff attended one of the meetings as assigned. Department-wide orientation was completed and each associate was individually checked off by the housekeeping manager as understanding and comprehending the specific item. All records were placed in the manager's associate files. Infection Preventionist will conduct monthly rounding on all housekeeping carts and interview a minimum of 2 housekeepers to ensure use of an approved Disinfectant for hospital surfaces. Preventionist will also, in conjunction with the Housekeeping Manager, conduct semi-annual education with the housekeeping staff in regard to specifications of products and what organisms are susceptible to each product. ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for this Plan of Correction.</p>		

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	<p>conference, staff member #A5 indicated he/she called the company regarding this issue and was told there was a similarly named product that was a disinfectant and apparently there was some miscommunication.</p> <p>4. Review of the employee file for environmental staff member #A21 indicated a training packet with the staff member's name written on the top, but without any date or signatures of any actual training.</p> <p>5. The employee files for environmental staff members #A22 and A23 lacked any documentation of training or orientation.</p>				