

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005002</p> <p>Survey Date: 8-18/21-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Jacqueline Brown , RN Public Health Nurse Surveyor</p> <p>Lynnette Smith Medical Surveyor</p> <p>QA: cloughlin 09/10/14</p>	S000000		
S000330	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p>			

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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on review of policies and procedures, personnel records, and staff interview, the chief executive officer failed to ensure annual tuberculin skin testing (TST) was performed, as required by hospital policy, for 4 of 6 dietary personnel reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 8-19-14 at 11:11, review of policy/procedure titled: "Tuberculosis Surveillance Program," policy number "EH_13," approved on "05/14," read: "Annual TST is required for healthcare workers in: Food Service..." On 8-19-14 at 10:35 AM, review of personnel records indicated the following: <ol style="list-style-type: none"> The last TST for Staff Member #L22 was performed on "7/15/13." The last TST for Staff Member #L23 was performed on "3/29/13." The last TST for Staff Member 	S000330	<p><u>ACTION ITEM (TB Testing for Food & Nutrition Employees):</u> All Food and Nutrition employees with missing TB tests received their TB test by August 22, 2014.</p> <p><u>Prevent Recurrence:</u> On the 15th of every month, the Manager of Employee Health notifies the Director of Food and Nutrition of the employees who are due for a TB test in the next month. The Director of Food and Nutrition ensures staff receive their TB test on time. Staff who do not receive their TB test on time will not be allowed to work until TB testing is complete.</p> <p><u>Responsible Person:</u> Director, Food & Nutrition <u>Completion Date:</u> 8/22/14 <u>Status:</u> Complete</p>	08/22/2014

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S000406	<p>#L24 was performed on "5-22-13." d. The last TST for Staff member #L25 was performed on "6-3-13."</p> <p>3. In interview on 8-19-14 at 1:15 PM, Staff Member #L11 acknowledged the TSTs for staff members #L22 through #L25 were overdue.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include standards for 2 services provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p>	S000406	<p><u>ACTION ITEM (Quality Review of 2 Contracted Services):</u> Quality standards have been established for monitoring contracted services for blood bank and tissue transplant.</p> <p>American Red Cross (Blood Bank):</p> <ul style="list-style-type: none"> · Ability to provide safe products · Ability to meet the routine 	08/29/2014			

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S000554	<p>1. Review of the facility's QAPI program indicated it did not include standards for the contracted services of blood bank and tissue transplant at both the Northlake and Southlake hospitals.</p> <p>2. In interview, on 8-20-14 at 11:40 am, employee #A6 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 interview and document review, the hospital created 2 conditions which failed to provide a healthful environment that minimized infection exposure and risk to patients.</p> <p>Findings:</p>	S000554	<p>needs</p> <ul style="list-style-type: none"> Ability to meet emergency needs Timely delivery of products Technical Support & Reference Lab Educational Support <p>Tissue Vendors (All):</p> <ul style="list-style-type: none"> Timeliness of delivery Integrity of tissue <p>Prevent Recurrence: Quality review for these contracted services has been added to the established quality review process for all contracted services.</p> <p>Responsible Person: Director, Lab and Manager, Surgical Services Completion Date: 8/29/14 Status: Complete</p> <p>ACTION ITEM (Testing of Test Strips in Ultrasound): The policy for testing test strips was in place at the time of survey (attachment A). The policy and procedural steps were reviewed with staff during the August Ultrasound Department meeting on</p>	08/21/2014	

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	<p>1. While on tour of the ultrasound area at the Northlake hospital, an ultrasound employee indicated a product entitled VERIFY chemical Monitoring Strip for Resert Solution was used to test the ultrasound probe disinfecting solution (Resert).</p> <p>2. Review of the instructions for the chemical monitoring strip indicated it is recommended that the testing of positive and negative controls be performed on each newly opened test strip bottle of Verify Chemical Monitoring Strip for Resert Solutions.</p> <p>3. The ultrasound employee was requested to provide documentation of testing of the newly opened test strip bottle of Verify Chemical Monitoring Strip for Resert Solutions. The employee indicated there was no documentation and none was provided prior to exit.</p> <p>4. Review of POLICY NO.: PACU-SFT_07, entitled Patient Safety, approved 1/14, indicated Linen will be stocked on a covered cart.</p> <p>5. On 8-20-14 at 3:20 pm in the presence of employee #A6 and #A16, it was observed in the linen storage area of the Southlake hospital, there were 15 linen</p>		<p>8/21/14 to verify staff understanding of the process. Although staff have access to on-line policies, a hard copy of the policy was distributed to each staff member to ensure clarity of the testing process.</p> <p>Prevent Recurrence: Staff were re-evaluated on their knowledge and practice of this process at the September monthly department meeting. Documentation of the process will be monitored weekly for 3 months. If documentation shows 100% compliance, the process will be monitored periodically thereafter to ensure ongoing compliance.</p> <p>Responsible Person: Interim Director, Diagnostic Imaging Completion Date: 8/21/14 Status: Complete</p> <p>ACTION ITEM (Uncovered Linen): The process for stocking linen carts was changed when the deficiency was identified during the survey. Previously, the linen cover was left up to notify each other that the cart was not fully stocked. Beginning August 20th, a note is now attached to the front of linen carts that are not completely stocked. The carts remain covered at all times.</p> <p>Prevent Recurrence: The process is monitored daily by</p>		

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S001118	<p>carts and 9 shelf rack units, all which contained clean linen and were not covered.</p> <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 document review, the hospital created conditions which resulted in a hazard to patients, public or employees in 2 instances.</p> <p>Findings:</p> <p>1. On 8-18-14 at 3:50 pm in the presence of employees #A6 and#A16, it was observed in the speech area at the Northlake hospital, there was an alcoholic hand-based sanitizer (ABHS) in a room with carpet but no overhead water sprinkler. The use of an ABHS in an area carpeted and without an overhead water</p>	S001118	<p>the Manager or Supervisor of Environmental Services.</p> <p>Responsible Person: Director, Environmental Services Completion Date: 8/20/14 Status: Complete</p> <p><u>ACTION ITEM (Alcohol Sanitizers in Carpeted Area):</u> The alcohol sanitizers located in the Speech Therapy Office at Northlake campus were removed on August 18th, immediately following identification by the surveyor. Staff were directed to use the sink available in the area to perform hand hygiene. Prevent Recurrence: Alcohol sanitizers were permanently removed. Responsible Person: Director, Plant Operations Completion Date: 8/18/14 Status: Complete <u>ACTION ITEM (Medical Gas Storage):</u> The small gas container was placed in an approved rolling rack</p>	08/22/2014			

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S001150	<p>sprinkler posed a fire hazard if the alcohol substance got into the carpet.</p> <p>2. On 8-20-14 at 4:00 pm in the presence of employees #A6 and #A16, it was observed in the gas storage area at the Southlake hospital, there was 1 small compressed gas cylinder leaning upright on a shelf unsecured by chain or holder.</p> <p>3. Review of POLICY NO.: SAF_26, entitled Medical Gasses (Compressed Tanks), approved 8-5-2014, indicated all medical gases are stored either in gas carts (E-tanks) or secured in the upright position by chains.</p> <p>4. If the tank was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <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</p>		<p>on August 20th, immediately following identification by the surveyor. Prevent Recurrence: The Director of Plant Operations is evaluating the option of eliminating the small gas container from the hospital's inventory. Ongoing compliance with medical gas storage is evaluated through regular rounding. Responsible Person: Director, Environmental Services Completion Date: 8/20/14 Status: Complete</p>				

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S001150	<p>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 a backflow prevention device 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 8-18-14 at 4:10 pm in the presence of employees #A6 and #A16, it was observed in a housekeeping storage area there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S001150	<p><u>ACTION ITEM (Back Flow Prevention Device):</u> A vacuum breaker was installed on August 18th, immediately following identification by the surveyor.</p> <p><u>Prevent Recurrence:</u> The identified water spigot is in compliance.</p> <p><u>Responsible Person:</u> Director, Plant Operations <u>Completion Date:</u> 8/18/14 <u>Status:</u> Complete</p>	08/22/2014			
S001164	<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 document review and</p>	S001164	<p><u>ACTION ITEM (Bio-Medical</u></p>	09/15/2014			

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	<p>interview, the hospital failed to provide evidence of preventive maintenance (PM) for 2 pieces of equipment.</p> <p>Findings:</p> <p>1. On 8-18-14 at 5:05 pm, employee #A6 was requested to provide documentation of PM on a standing box (a piece of physical therapy equipment), located in the physical therapy area of the Northlake hospital.</p> <p>2. In interview, at 11:15 am on 8-19-2014, employee #A16 indicated there was no documentation and no other documentation was provided prior to exit.</p> <p>2. On 8-20-14 at 3:00 pm, in the presence of employees #A6 and #A16, it was observed in the physical/speech therapy area of the Southlake hospital, a Gibson Freezer with a sticker on it that indicated Periodic Inspection Not Required.</p> <p>3. In interview, on 8-20-14 at 4:15 pm, employee #A21 indicated the above-stated sticker was the result of an alternative equipment maintenance assessment program conducted by the hospital. The employee was requested to provide documentation of a waiver from</p>		<p>Preventive Maintenance): A request for waiver of Indiana Hospital Licensure Rules was sent to the Indiana State Department of Health on September 15th (Attachment B).</p> <p>Prevent Recurrence: Upon acceptance of waiver request.</p> <p>Responsible Person: Director, Bio-Medical Engineering Completion Date: 9/15/14 (Awaiting acceptance of waiver request) Status: Complete</p>		

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S001186	<p>the State to implement such a program and the employee indicated there was no documentation of a waiver and none was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy in 7 instances.</p>	S001186	ACTION ITEM (Fire Drills): Fire drills (including off-sites) are now scheduled in the work order system. This improves our ability to track completion. All 2014 fire drills have been completed as required.	09/15/2014	

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	<p>Findings:</p> <p>1. Review of a document entitled Fire Safety Management Plan, SAF_05, approved 4/2014 indicated fire drills are conducted in all hospital and ambulatory healthcare facilities on each occupied shift each quarter ... Further review indicated fire drill are conducted in Methodist Hospitals Inc. Offsite (Business Occupancy) at least once a year exercising the applicable elements of the facilities' Fire Response Plan.</p> <p>2. Review of fire drills conducted at the hospital and 4 offsites for calendar year 2013, indicated the following:</p> <p>Methodist Hospital Northlake - no fire drill conducted 3rd quarter-3rd shift Methodist Hospital Southlake - no fire drills conducted 4th quarter-2nd shift and 3rd shift The Rehab Centers - no fire drills conducted Midlake Campus - no fire drills conducted Pillar Point - no fire drills conducted Methodist Diagnostic Center - no fire drills conducted</p> <p>3. In interview, on 8-21-14 at 10:00 am, employee #A16 confirmed the above and no further documentation was provided</p>		<p>Prevent Recurrence: The Director of Plant Operations ensures fire drills are performed as required.</p> <p>Responsible Person: Director, Plant Operations Completion Date: 9/15/14 Status: Complete</p>	

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

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