

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/16/2016
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NAME OF PROVIDER OR SUPPLIER  ESKENAZI HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 720 ESKENAZI AVENUE INDIANAPOLIS, IN 46202
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S 0000  Bldg. 00	This visit was for a standard licensure survey.  Facility Number: 005023  Survey Date: 03-14/16-2016  QA: cjl 04/20/16	S 0000		
S 0178  Bldg. 00	410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)  (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system. Based on observation, the hospital failed to conspicuously post the hospital's current license in an area open to patients and the public in 2 instances.  Findings:  1. On 03-16-2016 at 9:45 am in the presence of employees #A2, Safety	S 0178	The Environmental Safety Officer forwarded a copy of the ISDH 2016 License to the Residential Services Supervisor of Florence House and to the manager of the Narcotics Treatment Program for posting at their respective facilities on May 5, 2016. The signage was posted as requested on this date and was posted in the front entrance area of each facility. These sites are visited	05/05/2016

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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S 0270 Bldg. 00	<p>Officer and #A11, Maintenance Supervisor, it was observed at the offsite facility ENTRY NUMBER 6, Florence House, there was no current hospital license posted in an area open to patients and the public.</p> <p>2. On 03-16-2016 at 11:00 am in the presence of employee #A2, Safety Officer, it was observed at the offsite facility ENTRY NUMBER 12, Narcotics Treatment Program, there was no current hospital license posted in an area open to patients and the public.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to</p>	S 0270	<p>twice per year for environmental safety rounds. The posting of this document at every site listed as a component of the Eskenazi Health's state licensure will be assessed to verify that signage is appropriately posted. The Behavioral Health Risk and Regulatory Coordinator is ultimately responsible for compliance.</p> <p>The Quality Subcommittee of the Board meets four times per year, once per quarter. A new</p>	06/21/2016

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S 0308  Bldg. 00	<p>review reports of management operations for calendar year 2015 quality monitoring activities in 2 of 4 quarters.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the facility's governing board minutes for calendar year 2015 indicated there was no review of quality activities in the second quarter (April, May and June) nor the third quarter (July, August and September).</li> <li>Interview of employee #A12, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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</p>		Associate Vice President for Quality started with Eskenazi Health in May, 2015. A decision was made to not have a physical meeting during the second quarter of 2015, yet quality documents were distributed to the Board. However, there was no mention of these documents in the subsequent meeting of the Board. Another issue arose in late 2015 which necessitated the Board meeting's agenda to be altered, thereby the quality information that was discussed was not presented in the December 2015 Board meeting. Quality Subcommittee was held in March 2016 and the update was provided at the April 2016 meeting and was included in the April 2016 Minutes. The Quality Subcommittee is scheduled to be held during the second quarter on June 21, 2016 with the update to the full Board in July 2016. The Chief Medical Officer is responsible for quality and will be ultimately responsible for ensuring compliance with this requirement.		

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	<p>for the following:</p> <p>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the chief executive officer failed to ensure orientation to the hospital or the employee's job for one (#N11) of one contracted service providers.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Personnel document review of 11 facility employees on 3/16/2016 indicated that one contracted service personnel (#N11) lacked documentation of orientation.</li> <li>On 3/16/2016 at 1500 hours, staff member #N1 indicated that some of their service staff is contracted through CS1, who maintains personnel documents. Staff member #N1 also indicated that the facility had requested more documentation from CS1, but none was received by exit.</li> </ol>	S 0308	<p>On May 11, 2016 Eskenazi Health met with Clean Source, contracted EVS, to determine process for ensuring that orientation is completed and that files are maintained for each contracted staff member. The meeting involved Eskenazi Health's EVS director, HR manager, and a member of our Purchasing team and a representative of Clean Source's leadership. It was determined that moving forward there will be a defined process. All currently onboarded staff will be required to participate in an in person Eskenazi Health orientation. All new staff will attend an orientation session that will be conducted on a monthly basis. Further, all contracted staff will be required to meet the pre-employment orientation requirements as set forth in the contract. The vendor will provide documentation to Eskenazi Health Human Resources prior to allowing the employee to work. HR approval will be required before staff are allowed to work. EVS at Eskenazi Health will be responsible for completion of department-specific orientation and documentation of this training</p>	05/11/2016

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S 0406 Bldg. 00	<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 quality assurance and performance improvement (QAPI) program failed to maintain an effective, organized, hospital-wide ongoing program by lack of documentation of monitoring or evaluation of 28 services (Contracted blood bank service, CT (computed topography) scans, EEG (electroencephalography), EMG (electromyelography), contracted</p>	S 0406	<p>will be forwarded to HR at Eskenazi for filing. This process will facilitate compliance with the requirement for orientation and will ensure that files for contracted staff are available for Eskenazi Health at all times. The manager of HR at Eskenazi Health will be ultimately responsible for ensuring compliance.</p> <p>The Eskenazi Health Performance Improvement and Patient Safety Plan has been revised to be reflective of encompassing all system departments and contracted services. The revised plan will be forwarded to the Quality Subcommittee of the Board at the next meeting, June 21, 2016. The revisions will be completed by the AVP, Risk Management, Regulatory Readiness and</p>	06/21/2016

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	<p>housekeeping, infusion services, mammography, MRI (magnetic resonance imaging), neonatal nursery, nuclear medicine, post-operative recovery, emergency psychiatric services, psychology, security, outpatient surgical services, urgent care services, utilization review and 11 off-sites (OS1 - OS11) during the past 15 months.</p> <p>Findings:</p> <p>1. Review of the document titled Comprehensive Performance Improvement/Patient Safety Plan indicated the following:</p> <p>a. Scope of Plan: This plan applies to all venues affiliated with the hospital.</p> <p>b. Authority and Organizational Structure: 2.a. Performance Improvement Oversight Committee (PIOC): The Committee has primary responsibility for overseeing and prioritizing clinical and operational performance improvement activities.</p> <p>c. Performance improvement/quality assurance information/data flow into the Committee...Information/data is discussed, feedback given...and recommendations are made for subsequent presentation to the Board.</p> <p>d. The plan was reviewed/updated February 2014.</p>		<p>Patient Safety Officer. Revisions will be done to clearly identify each department/service/location that requires QAPI monitoring and activities. The document will include verbiage to indicate the Quality Sub Committee of the Board is giving approval to specific QAPI indicators as well as the expected timeframes for presenting information to the Board. Each of the services/locations lacking QAPI activities at the time of survey will have their activities reported prior to the end of the 3rd Quarter 2016. The AVP, Risk Management, Regulatory Readiness, and Patient Safety Officer is ultimately responsible for compliance with this citation.</p>	

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	<p>2. Review of facility quality documents indicated the following:</p> <p>a. Documents titled Quality Sub Committee Reports indicated the reports were evaluations of quality monitors and outcomes for 2014 and lacked documentation of ongoing quality monitoring or evaluation for the past 12 months.</p> <p>b. Documents titled Minutes dated 2/27/15, 3/27/15 and 4/24/15 and like documents titled PIOC Minutes dated 5/22/15, 6/26/15, 7/24/15, 8/28/15, 9/25/15 and 10/23/15 lacked documentation of monitoring or evaluation of the following: Contracted blood bank service, CT scans, EEG, EMG, contracted housekeeping, infusion services, mammography, MRI, neonatal nursery, nuclear medicine, post-operative recovery, emergency psychiatric services, psychology, security, outpatient surgical services, urgent care services, utilization review and 11 off-sites (OS1 - OS11).</p> <p>c. Documents titled Clinical Services Oversight Committee Minutes dated 11/17/15, 10/20/15, 9/15/15, 7/21/15, 6/16/15, 5/19/15, 4/21/15, 3/17/15 and 2/17/15 lacked documentation of monitoring or evaluation of the following: Contracted blood bank service, CT scans, EEG, EMG, contracted housekeeping, infusion services, mammography, MRI, neonatal</p>			

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S 0554 Bldg. 00	nursery, nuclear medicine, post-operative recovery, emergency psychiatric services, psychology, security, outpatient surgical services, urgent care services, utilization review, and 11 off-sites (OS1 - OS11).  3. On 3/16/16 at 1:15pm A1, Risk and Regulatory, indicated departmental reports/quality monitoring documentation of all services for the past 15 months was not available. A1 indicated the PIOC and quality committees do not monitor or evaluate ongoing activity of departments. They only review monthly reports and that each department reports to the committee 1 time per year. A1 verified lack of documentation of QAPI monitoring of the following: Contracted blood bank service, CT scans, EEG, EMG, contracted housekeeping, infusion services, mammography, MRI, neonatal nursery, nuclear medicine, post-operative recovery, emergency psychiatric services, psychology, security, outpatient surgical services, urgent care services, utilization review, and 11 off-sites (OS1 - OS11) within the past 15 months.  410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)			

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	<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 ensure a safe and healthful environment in three (3) instances regarding cleanliness of a placenta refrigerator in the Obstetrics unit, isolation procedures related to personal protective equipment (PPE) and hand hygiene protocol in the Burn Unit and storage of linen to protect from contamination in a Clean Linen Storage Room.</p> <p>Findings:</p> <p>1. Review of facility policy Refrigerator Quality Control, 950-116, last reviewed 3/27/2015, indicated</p> <p>POLICY: This policy and procedure applies to all refrigerators in all areas of Eskenazi Health which are used to store patient nourishment, patient medications and laboratory specimens or reagents.</p> <p>PROCEDURE: Cleaning of the refrigerators and freezers is the responsibility of the areas where they are kept.</p> <p>2. On tour of the Obstetrics unit accompanied by staff member # N10</p>	S 0554	<p>Immediate action was taken related to the condition of the placenta refrigerator at the time of survey. Ultimately, this resulted in a change with the nursing process of cleaning. The change included wiping the placenta pans off before placing them in the refrigerator. The research team, who utilizes this refrigerator, is responsible for cleaning out the refrigerator. They have been instructed of the need to clean the refrigerator and check for specimens daily. In the event the specimens are not needed, they are discarded. Nursing staff were informed of the need to wipe the placenta pans before placement in the refrigerator in an email from the OB manager and reviewed the information during April staff meetings. A log sheet was placed on the refrigerator to maintain accountability for assessing and cleaning of this refrigerator. The monitoring of the condition of the refrigerator and the log sheet will be conducted by the OB Clinical Managers. Issues with noncompliance will be brought to the attention of the OB Director. The OB Director is ultimately responsible for ensuring this refrigerator is cleaned. The issue with lack of hand hygiene was</p>	06/10/2016

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	<p>(OB- Director of Quality) on 3/14/2016 at 1115 hours, it was observed that the placenta refrigerator had specks of blood on all surfaces of the interior.</p> <p>3. At time of the observation, staff member # N10 indicated that he/she agreed with the finding.</p> <p>4. Review of Infection Control Isolation Procedures dated 01/2014 indicated on pages 9-10: A. (page 9), PPE must be donned prior to entering the isolation room. B. (page 10), table 4: contact: donning - prior to entering isolation room: hand hygiene, gown, gloves.</p> <p>5. Policy 950-144, Hand Hygiene, revised/reapproved on 6/5/15 indicated on page 1: A. (page 1), hand hygiene is required before and after all patient care. B. (page 1), hands must be sanitized or washed: before entering a patient's room, before direct contact with a patient, before donning and after removing gloves.</p> <p>6. While on tour of facility on 3/15/16 at approximately 1230 hours, accompanied by staff S10 (Director of Burn Center), staff S16 (Registered Nurse [RN]) entered patient's room, identified to be on contact isolation precautions, without</p>		<p>noted within the Burn Unit, however it was a dialysis nurse that was on the unit that did not perform hand hygiene and did not adhere to isolation procedures. An Infection Prevention and Control RN will meet with the dialysis (DaVita) director and the dialysis staff for mandatory education relative to essentials of hand hygiene, the hand hygiene policy, and isolation education. The isolation education will be inclusive of types of isolation, appropriate PPE, and will include a hands-on competency of donning and doffing PPE. All DaVita staff will be required to participate in these trainings prior to May 31, 2016. The DaVita Director will be ultimately responsible for compliance. Hand Hygiene audits are already conducted throughout the organization and are inclusive of Dialysis staff. The auditing of staff utilizing the proper PPE will be included as a part of our Safety Environmental Rounds. This process will continue under the direction of the Infection Prevention and Control Manager. The linen was removed from the shelving on March 16, 2016 by the EVS Director. The linen was moved from shelving and placed on a covered linen cart. The covered linen cart is now utilized to transport linen to the specific units. The shelving in which the linen was found will be completely removed from the</p>	

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	<p>performing hand hygiene and donning PPE.</p> <p>7. Staff S10 was interviewed on 3/15/16 at approximately 1235 hours and confirmed staff S16 (RN) entered burn patient's room identified to be on contact isolation precautions without performing hand hygiene and donning PPE and confirmed all staff are to follow facility policy and procedure for hand hygiene and isolation procedures.</p> <p>8. Policy #941-4, Infection Control of Linen, revised/reapproved on 8/27/15 indicated clean linen will be protected from contamination and soiling ...stored linen will be covered.</p> <p>9. While on tour of facility on 3/15/16 at approximately 1100 hours, in the presence of staff A2 (Safety Officer), staff A4 (Clinical Engineer) and staff A6 (Operations Supervisor), in the Clean Linen Storage Room, 9 shelves on racks which contained clean linen, including scrub suits, had no covering.</p>		<p>area by May 31, 2016. The EVS Director will monitor the linen area for compliance on a weekly basis. Infection Prevention and Control Manager will perform audits of this area quarterly. Issues with noncompliance found on either of these assessments will be corrected when noted. Instances of noncompliance found during the IPC quarterly audits will be brought to the attention of the Infection Prevention and Control Committee for further direction. The EVS Director is ultimately responsible for compliance.</p>	

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S 0948 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(5)</p> <p>(c) Drugs and biologicals shall be prepared for administration and administered as follows:</p> <p>(5) In accordance with currently acceptable standards of practice. Based on document review, observation and interview, the facility failed to ensure drugs are prepared for administration in accordance with current standards of practice for 1 of 5 (Operating Suite) areas toured.</p> <p>Findings:</p> <p>1. Policy 950-242, Sterile Medications, 950-242, revised/reapproved 6/5/15 indicated on page 2:  A. (page 2), prior to withdrawing from a sterile vial, the rubber diaphragm of the vial shall be swabbed with 70% isopropyl alcohol.  B. (page 2), proper aseptic technique practices shall be used during the preparation and administration of injected medications.</p>	S 0948	<p>The Service Chief for Anesthesia Services spoke with the resident involved with this citation on the date of survey. The resident was unaware of the need to swab a newly opened vial. The Service Chief for Anesthesia explained to this resident that it was appropriate to swab every vial prior to removal of medication. The resident apologized for his error and voiced understanding of this requirement. The education regarding the need to swab all vials will be presented by the Service Chief for Anesthesia at Anesthesia Grand Rounds on May 11, 2016. The information will also be presented on an ongoing basis when new residents orient to Eskenazi Health. Further, the information was presented to the OR Pharmacy Committee, a multidisciplinary team, who</p>	05/31/2016

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	<p>2. While on tour of facility on 3/15/15 at approximately 1400 hours, accompanied by staff S12 (Director of Surgical Services), staff S17 (Anesthesia Resident) was observed preparing for administration of injectable medication without using proper aseptic technique practices including the lack of swabbing rubber diaphragm of vial with 70% isopropyl alcohol prior to withdrawing medication from vial with syringe.</p> <p>3. Staff S12 was interviewed on 3/15/15 at approximately 1430 hours and confirmed staff S17 had prepared and administered injectable medication without use of aseptic technique and confirmed all staff are to follow facility policy and procedure for sterile medications.</p>		<p>addresses practice issues within the perioperative setting. The education for the distribution of this information will be monitored on a monthly basis. The Clinical Pharmacy Tech Supervisor conducts monthly orientation for Anesthesia residents. The information regarding the requirement to wipe every vial, including newly opened, will be communicated during these sessions. The information will be a part of the document that all incoming residents sign acknowledging they have received and understand the information. These sheets will be collected and maintained. Those residents not signing the document will be communicated to the Service Chief for Anesthesia Services for follow up. Anesthesia Attending Physicians will be conducting observations for the Resident Physicians to ensure that proper swabbing of the vials are occurring. Education will occur with the residents at the time of noncompliance. Issues with repeat noncompliance will be brought to the attention of the Service Chief for Anesthesia. The Service Chief for Anesthesia Services is ultimately responsible for compliance.</p>	

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S 0952 Bldg. 00	<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 hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedures for four (4) of twenty-five (25) patients.</p> <p>Findings include:</p> <p>1. The policy, "Obtaining/Administering Blood and Blood Components, 600-004, revised 6/16/15, read: "The transfusionist and witness must sign the transfusion record form (TRF). All vital signs must be completed and documented fifteen minutes after transfusion is begun: Between the first 10 and 20 minutes of infusion, take and record vital signs including temperature, heart rate, respirations, and blood pressure.</p>	S 0952	<p>On April 19, 2016 the Transfusion Medicine Supervisor began tracking the transfusions with incomplete documentation in a spreadsheet. The spreadsheet is then forwarded to a quality improvement nurse auditor or a manager in the OR, who will provide the follow up with direct leadership of the staff performing the incomplete documentation. The results from these audits will be brought monthly to Nursing Quality Council. On May 3, 2016 the issues with incomplete documentation were discussed at the Nursing Quality Council. This team made the decision to implement a Transfusion Task Force to further refine transfusion documentation education and follow up. This team has been developed and will report follow up items at the next Quality Council meeting. The Chief Nursing Officer is ultimately</p>	06/07/2016

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	<p>Blood and blood components should be infused within 4 hours of issue."</p> <p>2. Review of the documentation for four patients, each receiving one blood unit, indicated documentation, per policy, on the Transfusion Record form was incomplete including:</p> <p>--Unit 6a, was administered on 1/22/16 at 01:45 p.m.: The unit's 10-20 vitals were documented at 2:10 p.m. (25 minutes).</p> <p>--Unit `13a, was administered on 12/04/15 at 07:42 a.m.: The 10-20 minute vitals were documented at 07:47 a.m., which was at 5 minutes (5 minutes early) in lieu of at 7:52 a.m. (beginning at 10 minutes).</p> <p>--Unit 16b, was administered on 11/14/15; however, the transfusionist 'print' line name had not been filled in.</p> <p>--Unit 22a, was administered on 10/02/15 at 2:40 p.m.: The unit was issued from the blood bank at 2:31 p.m. and completed at 7:00 p.m. which was 4 hours 29 minutes in lieu of within 4 hours.</p> <p>3. On 03/16/16 at 9:15 a.m., staff member #A8 acknowledged that the four</p>		responsible for compliance with transfusion practices and documentation.				

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S 1024 Bldg. 00	<p>above-listed patient blood units had incorrect or incomplete documentation, per the blood administration policy.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</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>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on document review, observation, and interview, the hospital pharmaceutical service failed to ensure detection and quarantine of outdated or otherwise unsafe drugs for 2 vials of medication in 1 area (outpatient pharmacy).</p> <p>Findings:</p> <p>1. Review of the policy titled Return to Stock/Hold Prescription, 731-631 indicated: When returning medications to stock, medication will be left in</p>	S 1024	<p>The manager of outpatient pharmacy services developed an "Outpatient Care Center Pharmacy Cleaning Assignment" document on March 28, 2016.</p> <p>This document divides up all areas of the pharmacy and assigns maintenance responsibility to designated individuals. The documents identifies that specific individuals are now responsible for cleaning their sections and pulling outdated product on a weekly basis. The document is developed as a 6-week document to match the outpatient work</p>	04/08/2016

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	<p>prescription vial... Return to stock medications that do not have an expiration date on the container will be considered to be expired 30 days after dispensation. The policy was approved 12/9/15.</p> <p>2. Review of the policy titled Expired Medication, 731-404, indicated: Expired medications shall be removed from stock areas and processed by pharmacy personnel... The policy was approved 1/15/14.</p> <p>3. On 3/16/16 at 10:40am, in the presence of S1, Manager of Outpatient Pharmacy, on a shelf of stock medications, among manufacturers' bottles of medications were 2 vials of pills with labels as follows: a. Hydroxyzine HCL 10mg tab. 90 tabs. Dispensed 2/2/16 b. Hydroxyzine HCL 10mg tab. 60 tabs. Dispensed 2/12/16</p> <p>4. On 3/16/16 at 10:40am, S1 indicated dispensed medications returned to stock are to be removed from inventory 30days after the dispense date and that the above medications were expired.</p>		<p>schedule so that the names on the cleaning schedule are consistent with the individuals on the work schedule. Area assignments were forwarded to staff and tracking sheets to monitor the process on April 8, 2016. All outpatient pharmacy staff members received education on the plan on April 14, 2016 at the staff meeting. Compliance will be monitored by the pharmacy operations supervisors and the senior pharmacists. Ultimately, the responsibility for compliance is assigned to the manager of outpatient pharmacy services.</p>				

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S 1118  Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 6 instances.</p> <p>Findings include:</p> <p>1. On 03-15-2016 at 10:10 am, in the presence of employees #A4, Clinical Engineer, #A5, Assistant Vice President Facilities and #A6, Operations Supervisor, the following was observed in the hazardous material storage shed:</p> <p>11 small compressed gas tanks each containing carbon dioxide mixed with other gases, stored on a shelf unsecured by chain or holder</p> <p>5 small compressed gas tanks with a mixture of anesthetic gases, stored on a</p>	S 1118	All compressed gas tanks within the hazardous material shed were secured with a chain on May 5, 2016 by a member of the Facilities staff. An assessment of the area specific to ensuring that gas tanks are secured has been added to the Environmental Safety Rounds. This assessment will become a regular assessment during rounds conducted by the Environmental Safety Officer. All findings of noncompliance will be immediately addressed and reported to the Environment of Care committee. The environmental services room housing a larger than acceptable amount of alcohol-based sanitizers will be corrected by removal of the 25 ounce bottles and 19 of the 38 ounce bottles leaving a total of approximately 8.6 gallons of alcohol-based sanitizers within this area. The timeframe for removal of this	05/30/2016

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	<p>shelf unsecured by chain or holder</p> <p>2. If any of the above tanks were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>3. On 03-15-2016 at 11:45 am, in the presence of employees #A4, Clinical Engineer, #A5, Assistant Vice President Facilities and #A6, Operations Supervisor, the following amounts of alcohol-based hand sanitizers was observed in the environmental services room:</p> <p>11 each 25 ounce bottles of alcohol-based hand sanitizer (ABHS) = 275 ounces 11 each 16.9 ounce bottles ABHS = 186 ounces 60 each 25 ounce bottles ABHS = 1500 ounces 38 each 33.8 ounce bottles ABHS = 1284 ounces</p> <p>4. The above total amount of ABHS is 3284 ounces. There are 128 ounces in a gallon. Therefore, there were <math>3284/128 = 25.6</math> gallons of ABHS in 1 smoke compartment in the hospital. This exceeded the allowable aggregated amount of 10 gallons.</p>		<p>quantity will be by May 20, 2016. An assessment of the area specific to ensuring that the total volume of alcohol-based sanitizers does not exceed the 10 gallon limit has been added to the Environmental Safety Rounds. This assessment will become a regular assessment during rounds conducted by the Environmental Safety Officer. All findings of noncompliance will be immediately addressed and reported to the Environment of Care committee. The EVS Director will be educated on the need to make frequent assessments of this area to facilitate ongoing compliance. All wall mounted alcohol-based hand sanitizers are targeted to be removed completely from Florence House. The wall mounted alcohol based sanitizers will be removed as soon as pump bottles of sanitizer arrive to the facility. The pump bottles will be</p>	

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S 1150 Bldg. 00	<p>5. On 03-16-2016 in the presence of employees #A2, Safety Officer and #A11, Maintenance Supervisor, the following was observed at the offsite ENTRY NUMBER 6, Florence House:</p> <p>9:50 am - 1 ABHS on the wall in the entry hall 10:00 am - 1 ABHS on a table in the patient (resident) lounge area 10:30 am - 1 ABHS on a wall in the hallway adjacent to Patient Room #1 10:40 am - 1 ABHS in the staff office, next to the mechanical equipment closet</p> <p>6. In each of the above-stated instances, the areas were carpeted and did not have an overhead water sprinkler.</p> <p>7. The use of an ABHS in an area carpeted and without an overhead water sprinkler posed a fire hazard if the alcohol substance got into the carpet.</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</p>				<p>located in the kitchen/eating area and one in the nurses area at Florence House. The expected completion date for removal will be no later than May 30, 2016. The Environmental Safety Officer is ultimately responsible for compliance with these findings.</p>		

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S 1186 Bldg. 00	<p>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 a 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 0-3-16-2016 at 10:25 am in the presence of employees #A2, Safety Officer and #A11, Maintenance Supervisor, it was observed in a patient bathroom at offsite ENTRY NUMBER 6, Florence House, there was a flexible shower hose connected to a water spigot without a backflow prevention device.</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>			S 1150	<p>This issue was corrected by shortening the flexible shower hose so that it does not reach the water level. Additionally, to enhance compliance, a vacuum breaker will be installed at this location on or before May 27, 2016 by the clinic maintenance staff. This issue will be monitored semi-annually during environment of care safety rounds by the Environmental Safety Officer, who is ultimately responsible for compliance with this issue.</p>		05/02/2016

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	<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's fire control plan failed to contain a provision for cooperation with firefighting authorities in 1 instance.</p> <p>Findings:</p> <p>1. Review of facility's fire control plan, approved May 16, 2014, indicated it contained no provision for cooperation with firefighting authorities.</p> <p>2. In interview, on 03-16-2016 at 3:15 pm, employee #A2, Safety Officer, confirmed the above and no further documentation was provided prior to exit.</p>	S 1186	<p>The Environmental Safety Officer amended the Eskenazi Health Fire Response Plan to include the information cited on this deficiency. The change was made on March 21, 2016. The change was made within the first paragraph of the plan to include the following verbiage "Upon arrival of the responding fire agency, all employees will follow directions issued by them." The Fire Response Plan was updated in the official binder on March 21, 2016. The updated Eskenazi Health Plan was updated on the internal EHub on May 6, 2016.</p> <p>This site is where staff members resource internal information. The information will be communicated to new staff during new employee orientation sessions from this point forward. Current staff will be educated on this update during environmental safety rounds and during fire drills on an ongoing basis. The</p>	03/21/2016

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			Environmental Safety Officer is ultimately responsible for compliance with this deficiency.		