

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 8/24/2015 through 8/25/2015 Facility Number: 005008 QA: cjl 09/14/15	S 0000	Please accept this plan of correction to be considered as our credible allegation of compliance.	
S 0606 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii) (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: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review and staff interview, the facility failed to determine	S 0606	The Governing Board and the Chief Executive Officer assure that the hospital has an	10/09/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150008	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the communicable disease history of health-care personnel (HCP) for 4 of 11 (#1, 5, 6 and 11) personnel records reviewed.</p> <p>Findings:</p> <p>1. Policy #5.6, titled "Employee Exposure to Varicella/Herpes Zoster", revised/reapproved 8/13, was reviewed on 8/25/15 at approximately 1405 hours, and indicated on pg. 3, under Policy Statement/Purpose section, point 9.0, "At this time, Varicella vaccine is not offered by the Employee Health Service. Employees who are determined to be non-immune to varicella by titer testing will be strongly encouraged to seek vaccination through their personal physician."</p> <p>2. CDC (Centers for Disease Control and Prevention) Recommended Adult Immunization Schedule and Guideline for Infection Control in Hospital Personnel was reviewed on 8/25/15 at approximately 1400 hours, and indicated on pg. 2, point:</p> <p>A. "4. Varicella vaccination: All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose...Evidence of</p>		<p>established Infection Control Committee that monitors and guides the infection control program, including but not limited to reviewing and recommending changes in procedures, policies, and programs, including those that pertains to determination of communicable disease history of new personnel as required by state and federal agencies Policy #12.0, titled "Measles (Rubeola), Mumps and Rubella (German Measles) and Varicella (Chicken Pox) Immunizations for Healthcare Workers" was developed to comply with the CDC's (Centers for Disease Control and Prevention) Recommended Adult Immunization Schedule and Guideline for Infection Control in Hospital Personnel: See Attachment A</p> <p>The policy was approved by the Chairman of the Infection Control Committee, VP of Patient Care Services and the CEO. The Infection Control Nurse and the Employee Health Nurse is responsible for inservicing the managers of different departments regarding the policy. The managers of departments are responsible for inservicing their staff on the requirements. The Employee Health Nurse reviewed the communicable disease history of current hospital healthcare personnel to determine who needed the required vaccinations. A letter was sent to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150008	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>immunity to varicella in adults includes any of the following: documentation of 2 doses of varicella vaccine at least 4 weeks apart; U.S. (United States) born before 1980 except health-care personnel (HCP) and pregnant women; history of varicella based on diagnosis or verification of varicella disease by a health-care provider; history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health-care provider; or laboratory evidence of immunity or laboratory confirmation of disease."</p> <p>B. "7.:</p> <p>a. Measles, mumps, rubella (MMR) vaccination: All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps, or rubella.</p> <p>b. HCP born before 1957: For unvaccinated HCP born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval</p>		<p>identified healthcare personnel of the need to be vaccinated . The Employee Health Nurse began conducting titers and provided vaccines to No- immune employees, starting with newly hired staff and will continue to do so focusing on a different segment of our employee population every 30 days, until all employees have been properly immunized. The Employee Health Nurse will be responsible for documenting compliance to the standards in the employee's medical records. Non - compliance to the standards will result in disciplinary actions issued by the managers to the staff. The Employee Health Nurse/designee will monitor compliance to above policy by reviewing employees records until 100% compliance is achieved for four months. Results of the monitoring/review will be reported to the Infection Control Committee by the Employee Health Nurse.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150008	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>for measles and mumps or 1 dose of MMR vaccine for rubella."</p> <p>3. Review of personnel records on 8/25/15 at approximately 1210 hours, indicated staff number: A. 1, 5, 6 and 11: a. lacked proof of immunity to varicella by documentation of 2 doses of varicella vaccine at least 4 weeks apart; history of varicella based on diagnosis or verification of varicella disease by a health-care provider; history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health-care provider; or laboratory evidence of immunity or laboratory confirmation of disease. B. 5, 6, and 11: b. lacked documentation of 1 or more doses of MMR vaccine; or medical contraindication to the vaccine; or laboratory evidence of immunity to Rubeola (measles).</p> <p>4. Staff 1 (Infection Control Preventionist) was interviewed on 8/25/15 at approximately 1415 hours and confirmed the above-mentioned personnel records were lacking documentation of communicable disease history and/or immunity to varicella and/or MMR related to Rubeola. The facility follows the CDC Guideline for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150008	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0612 Bldg. 00	<p>Infection Control in Hospital Personnel. A policy specific to Rubeola immunity for all HCP was not available.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on observation and staff interview, the hospital failed to ensure clean room divider curtains were stored in a clean and sanitary environment in the Clean Storage Room.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 8/25/2015, Clean Storage Room that stores clean room divider curtains were observed stored in the room with two large soiled two-wheel dollies. The dollies were observed with</p>	S 0612	The two dirty dollies were immediately removed from the clean storage room and were placed in the dirty storage room. The Director of Environmental Services inserviced his staff as to proper storage of clean linen. No dirty items will be stored in the Clean Storage Room. The Environmental Staff is accountable for following the requirement for storing only clean items in the Clean Storage Room. The Director of Environmental Services is responsible for ensuring the standards pertaining	09/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150008	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 1118 Bldg. 00	<p>the end of the dolly under the curtains and one dolly was in direct contact with a clean curtain.</p> <p>2. At 1:50 PM on 8/25/2015, staff member #17 (housekeeping staff) indicated the curtain storage room was a clean room and the two dollies are dirty and should not be stored in the same room.</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 document review and staff interview, the facility failed to ensure the six operating rooms met the required humidity levels as defined by hospital policy and failed to ensure high-protein enternal tube-feeding supplements were stored properly in the Store Room</p>	S 1118	<p>to Clean Storage Room is followed by his staff. Non compliance to the standard will result in corrective action/s issued by the Director of Environmental Services. The Director of Environmental Services will monitor the Clean Storage Room for appropriate storage of items weekly until 100% compliance is achieved for four months. The Director of Environmental Services will include monitoring of the Clean Storage Room in his monthly Environment of Care rounds/surveillance to assure continued compliance.</p> <p>The Director of Surgical Services is responsible for ensuring that the six operating rooms met the required humidity levels as defined by hospital policy number "OR 70.0: Humidity and Temperature Monitoring in the Operating Rooms, Endoscopy Suites and Sterile Processing."</p>	09/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150008	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2015
NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Department.</p> <p>Findings included:</p> <p>1. St. Catherine Hospital Humidity and Temperature Monitoring in the Operating Rooms, Endoscopy Suites and Sterile Processing policy #OR 70.0 (last revised July 2015) stated, "To ensure that the temperature and humidity in applicable areas are being monitored and maintained within recommended standards in the interest of patient safety with respect to both fire safety and infection control." The policy requires the work area for the Operating Room to have the temperature between 68 and 72 degrees Fahrenheit and humidity range is between 20 to 60%.</p> <p>2. Computerized sensor graphing charts were reviewed for 6 operating rooms between May 24, 2015 and August 24, 2015. The graphing charts for the 3 months evidenced the 6 operating rooms exceeded the required humidity levels of 60%. The average humidity level for the 3 operating rooms was 71%.</p> <p>3. At 1:00 PM on 8/25/2015, staff member #11 (Director of Engineering) confirmed the sensor readings exceeded the required humidity levels of 60%. The staff member indicated the thermostat in</p>		<p>See Attachment B The Director of Surgical Services reviewed the policy with her staff, including but not limited to the required humidity and temperature levels and the associated action plan when levels are not within the requirements. The Surgical Services staff are responsible for compliance with the policy. Non-compliance will result in corrective actions issued by the Director of Surgical Services. The HVAC controls of the individual rooms were updated from pneumatic to electric. This will allow us to better monitor the temperature and humidity of the rooms and better assist staff in making adjustments when readings are out of the required ranges. The Surgical Services staff is responsible for checking the temperature and humidity levels of the room daily and to implement action plan as described in the policy when needed. The Plant Operation is responsible for keeping the computerized daily logs for the temperature and humidity levels. The Surgical Services staff is responsible for documenting action plan taken when temperature and humidity levels are out of required range. Compliance with the required temperature and humidity levels will be checked monthly, during the monthly Environment of Care Rounds. Results will be reported to the Safety</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150008	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the operating rooms have different humidity level readings; however, the staff member indicated the operating room nursing staff did not maintain a log confirming the different results.</p> <p>4. At 2:15 PM on 8/25/2015, the Store Room was observed storing loose assorted nutritional tube-feeding supplements on shelving units under florescent ceiling lights. The department contained the following observed items stored in direct florescent lighting: Osmolite 1.2 cal; Jevity 1.5 cal; Glucerna 1.0 cal; Jevity 1.0 cal; and etc.</p> <p>5. The manufacturer product label of the assorted enternal ready-to-eat nutritional supplements states, "Contain light sensitive nutrients." The manufacture indicates artificial light degrades vitamins such as riboflavin (B2), B6, and vitamin A. Vitamin losses occur gradually at low light exposure and faster in bright light. The manufacturer states, "Store product in the shipper or store on covered shelves or in closed cabinet prior to use."</p>		<p>Committee. The Manager of the Store Room is responsible for ensuring that high protein enteral tube feeding supplements are stored properly All items exposed to light were destroyed on 8/26/15, no stock is exposed to light as required by the manufacturers. All clear plastic enteral feeding formula containers were stored in the cardboard shipping boxes to prevent exposure to light, and will be removed only when the feeding is sent to the nursing unit The entire Storeroom Staff has been educated by the Storeroom Manager on the above requirements. Non compliance to the above requirements will result in corrective actions issued by the manager of the department. Compliance to the requirement will be checked during the monthly Environment of Care rounds.</p>	