

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150100	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/05/2013
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NAME OF PROVIDER OR SUPPLIER  ST MARY'S MEDICAL CENTER OF EVANSVILLE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WASHINGTON AVE EVANSVILLE, IN 47750
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005089</p> <p>Survey Date: 12-2/5-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Saundra Nolfi, RN Public HealthNurse Surveyor</p> <p>QA: 12/16/13</p>	S000000		

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

TITLE

(X6) DATE

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

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S000178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(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.</p> <p>Based on observation, the hospital failed to conspicuously post the hospital license in 1 area open to patients and the public.</p> <p>Findings:</p> <p>1. On 12-4-13 at 10:50 am in the presence of Employee #A10, it was observed in the offsite housing Lab, EKG and Radiology areas, there was no hospital license posted in an area conspicuously open to patients and the public.</p>	S000178	<p>Plan of correction: The Indiana State Licensure was posted on January 3, 2014 in the main lobby area of Bellemeade Office Building, the off-site housing Lab, EKG, and Radiology. A copy of the license was also e-mailed to all of St. Mary's off-site entities with instructions to ensure the license is posted in an area visible to the patients and public. This requirement has been added to our off-site Joint Commission and environmental tracers to assure compliance. This will be ensured by the Directors of all off-site facilities and followed-up by Risk and Accreditation through off-site tracers.</p>	01/03/2014	

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S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</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:  (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and staff interview, the chief executive officer failed to ensure Radiation policies and procedures were reviewed and/or approved triennially and failed to adopt contracted foodservice policies and procedures that the Dietary Department was utilizing.</p> <p>Findings included:</p> <p>1. Policy and Procedure Development policy #100018 (last approved 1/16/13) stated, "All policies are reviewed and/or revised at least every three years."</p>	S000322	<p>This statement of corrections includes items 1 through 4: The policies, RADIATION RULES FOR FLOUROSCOPY; RADIATION PROTECTION FOR EMPLOYEES; RADIATION DOSIMETRY FILM BADGES; AND RADIATION FILM BADGES are being revised by the Manager of Radiological Services, to be approved by the Executive Director over Radiological Services by January 31, 2014. The process was changed to ensure the radiology staff are keeping the dosimetry badges at work in a common area. The information was presented to the Radiology staff on campus on December 17, 2013 and communicated by the Radiology Manager to the off-campus Radiology sites. Badge holders are being made for the Radiology staff. In the meantime, the staff</p>	03/01/2014	

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	<p>2. Review of the facility 4 Radiation policies: Radiation Rules for Fluoroscopy; Radiation Protection for Employees; Radiation Dosimetry Film Badges; and Radiation Film Badges, indicated the policies were last reviewed and approved June 2007.</p> <p>3. Review of the contracted foodservice policies and procedures indicated the policies and procedures had not been reviewed and approved by the hospital.</p> <p>4. At 3:15 PM on 12/4/2013, staff member L3 indicated the Radiation policies have not been approved triennially by the hospital. The staff member also confirmed that the contracted foodservice was utilizing their company policies which have not been approved by the hospital.</p>		<p>have been instructed to keep them in their lockers. This has been added to the Joint Commission and environmental off-site tracers for the facilities with Radiology capabilities to ensure compliance. The Radiology Director and Executive Director of Ambulatory Operations will ensure compliance. Risk Management and Accreditation will follow-up with compliance through tracers. The Food Service policies are being reviewed and revised by the Director of Food and Nutrition Services. The revisions will incorporate St. Mary's specific requirements and protocols. When completed, the Vice-President of Clinical Support and Ancillary Services will review, approve and sign. These will be reviewed and revised, as needed, and, at a minimum, every two years. Date of completion March 1, 2014. The Director of Food and Nutrition Services and the Vice President of Clinical and Ancillary Services will assure compliance.</p>		

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S000406	<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 and staff interview, the hospital failed to ensure standards for 1 service directly-provided by the hospital and failed to include monitors and standards for 2 contracted services as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. The contract between the foodservice and St. Mary's Medical Center of Evansville was approved 2013.</p>	S000406	<p>This statement of correction includes items 1-6. The current PI project for Food and Nutrition Service for 2014 "to improve the overall quality of food delivered to the patients." Their goal is to exceed the 80th percentile. This is monitored through reports for test tray ordering. The Registered Clinical Dieticians order eight (8) trays each month. They evaluate them for accuracy of order, timeliness, and temperature. Data will be collected to define key areas of improvement. Action items will be identified to provide sustainable improvement. This PI will be reported every six (6) months, as assigned, to the ancillary Services Quality and Patient Safety Committee, which will be reported up to the Board. The Vice President of Clinical and Ancillary Services will</p>	01/06/2014
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	<p>The contract specifies that both parties have agreed to measure Supplier's performance with respect to the following performance areas: Patient Satisfaction, retail foodservice customer satisfaction, and employee satisfaction. The contract between the foodservice and St. Mary's Medical Center of Evansville Inc. shall adhere to all local, state, and Federal rules and regulations.</p> <p>2. The Quality Performance Improvement reports were reviewed. The contracted foodservice company had not been monitored and evaluated by the hospital.</p> <p>3. At 1:30 PM on 12/5/13, staff member #L2 confirmed that the contracted foodservice has not been monitored or evaluated for its performance standards.</p>		<p>ensure reporting of PI data and compliance. The PI project by the Registered Clinical Dieticians is "to improve the delivery of nutritional supplements to improve patient outcomes." By improving the delivery of nutritional supplements to the patients, there is the opportunity to improve patient outcomes, decrease length of stay, reduce patient costs, reduce complications, decrease development of depressive symptoms, reduce readmission rates and improve lean body mass recovery. A new process was developed to improve order communications and delivery of the nutritional supplements. The results demonstrated in September of 2013 showed an overall rate of 92% , which met the benchmark of greater than 90%. The Vice President of Clinical and Ancillary Services will ensure reporting of PI data and compliance. Environmental Services' PI project for 2014 is "continued improvement of patient and ancillary room cleaning to control infections and improve patient satisfaction." They are using a Team Coach web-based survey tool to gauge performance. Managers input data on inspections and Team Coach calculates compliance percentages. Our benchmark for Patient Satisfaction is 74%. we are currently at 82% but want to continue to improve. This is</p>		

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	<p>4. Review of the facility's QAPI program indicated it did not include standards for the directly-provided service of dietary nutritionists.</p> <p>5. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted housekeeping service provided at several offsites.</p> <p>6. In interview, on 12-5-13 at 10:50 am, employee #A11 confirmed the above and no further documentation was provided prior to exit.</p>		<p>measured through our HCAHPS score for "cleanliness". All Touch Point Environmental Services off-sites are monitored through the same process. The PI data collected from all of the above areas will be reported to the monthly Ancillary Services Quality Patient Safety Council every six months (6) as assigned, which will be reported up to the Board. The Vice President of Clinical and Ancillary Services will ensure reporting of PI data and compliance.</p>		

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S000554	<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 observation and interview, the hospital created 2 conditions (clean laundry section and main pharmacy) which failed to provide a healthful environment that minimized infection exposure and risk to patients and employees, failed to ensure a safe environment for patients by checking supplies to prevent outdated usage in four patient care areas (Same Day Surgery, Surgery, Endoscopy, and Mental Health)and failed to ensure clean supplies and equipment were protected from contamination in six patient care areas (Pediatrics, Neonatal Intensive Care Unit, Labor and Delivery, Nursery, Post-Partum, and 6 West).</p> <p>Findings</p> <p>1. On 12-3-13 at 12:05 pm, in the presence of employee #A10, it was observed in the clean laundry section, there was a considerable amount of dust overhead on the vents, lights, conduits and ducts. Some dust was observed falling onto the clean items such as</p>	S000554	<p>This statement of corrections is in response to items 1 through 15:Quotes have been obtained and an outside vendor. The Manager of Laundry under the supervision of the Vice President of Cclinical and Ancillary Services will schedule the cleaning of overhead lint/dust from vents, ceiling, lights , conduits and ducts. The cleaning schedule has been changed from annual to semiannual and as needed per ongoing observation and reporting by the Laundry Manager to the Vice-President of Ancillary Services. The cleaning will be completed by January 28, 2014. The Vice President of Clinical and Ancillary Services, Risk Management, and Accreditation will follow-up to ensure compliance. The Director of Pharmacy has followed up with the placement of shelving in nutritional supplement (enteral) product storage area. It has been covered with amber plastic sheeting. This was completed in December, 2013.A memo was posted in the storage area for pharmacy staff regarding storage of enteral products with the</p>	02/28/2014			

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	<p>sheets, thus contaminating them.</p> <p>2. On 12-3-13 at 3:10 pm in the presence of employee #A10, it was observed in the main pharmacy area, there were the following:</p> <p>10 each 400 ml bottles Jevity 1.5 cal nutritional supplement</p> <p>3 each 1000 ml bottles Jevity 1.2 cal nutritional supplement. Each of the bottles had a manufacturer's label indicating contains light sensitive nutrients. Each of the bottles was stored on an open shelf exposed to light. Due to the prolonged exposure to light, the items may have become ineffective.</p>		<p>following information: 1) All items should remain in original boxes when possible. 2) All bottles that have been removed from boxes (returned to shelving area) must be stored behind light protective sheeting. The Director of Pharmacy and the Vice President of Clinical and Ancillary Services will ensure compliance. The Accucheck control solution in Same Day Surgery was discarded immediately. A new one was opened and dated for expiration. Education was provided to the Same Day Surgery staff by the charge nurse through daily huddles and staff meetings in December, 2013. A new process has been established to check the solutions once a week by assigned staff to assure outdates do not occur. The Director of Same Day Surgery and the Executive Director of Perioperative Services will ensure compliance. Risk Management and Accreditation will follow-up with environmental tracers. The process in Surgery to improve compliance with outdates of supplies and medications, has been changed to completing the Emergency Cart checks at the end of each month, instead of at the beginning of the month. All items to expire by the end of the month will be removed. This was implemented on the weekend of December 20th. The responsibility has been assigned to the weekend option staff.</p>		

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			Education started on December 20, 2013 and will be on-going with Surgery Staff. The Director of Surgery or her designee will assure these checks are completed. The Direcotr of surgery and the Executive Director of Perioperative Services will ensure compliance. Risk Management and Accreditation will follow-up with environmental tracers.In regards to outside boxes being brought into clean areas, Environmental Services has taken the responsibility from Food Service. It has been assigned to a Supply Technician. They are removing the items from the boxes and placing on shelves or bins on each unit. This new process began December 16, 2013. We have communicated through leadership emails and Nursing Clinical Services that the outside boxes cannot be placed in the clean areas. It has been added to our Joint Commission and hospital environmental tracers to check lounges/patient food/clean storage for outside boxes. The Director of Environmental Services and the Clinical Nursing Directors are responsible to ensure compliance. Risk Management and Accreditation will follow-up with environmental tracers.In the case of Neonatal Intensive Care Unit (NICU), it was discovered that the box was left by a Mead Johnson representative. It was addressed with the Mead	

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			Johnson representative by the Director of NICU. It was also presented at the Neonatologists' meeting on January 7, 2014 and addressed with the physicians. The process has been changed so that all products come through purchasing. This ensures the products are removed from the boxes prior to coming onto the units. It has been added to our hospital environmental tracers to check lounges/patient food/clean storage for outside boxes. The Clinical Nursing Directors and the Executive Nursing Directors are responsible to ensure compliance. Risk Management and Accreditation will follow-up with environmental tracers. In the Nursery, the car seat box was removed immediately. It was discussed with the car seat technicians and the nursery staff the week of December 3, 2013 by the Director of the Nursery that boxes from the outside can not be stored with clean items. The Director of the Nursery and the Executive Director of Perioperative Services will be accountable for ensuring compliance. It has been added to the Joint Commission off-site and hospital environmental tracers to check lounges/patient food storage/clean storage areas for outside boxes. Risk Management and Accreditation will follow-up with environmental tracers. The outdated medication room have been	

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			removed. All IV fluids are now stocked in the supply scan (this was not the case in previous years and that is why there were IV fluids in that room). This room is no longer used for medication now that we have Pyxis down each hall. All floor stock meds stored in Pyxis have the expiration dates recorded in the software. Pharmacy runs regular reports to track and remove expired or soon to be expired meds. The Pharmacy Director and the Director of Post-Partum will ensure compliance. Risk Management and Accreditation will follow-up with environmental tracers. In regards to the outdated in the Endoscopy department, the Endoscopy Director is requiring that the staff will complete monthly checks of each room with medication, and sign to verify the room was checked. These checks will be monitored by the Director of Endoscopy, The Director of Endoscopy will ensure compliance. Risk Management and Accreditation will follow-up with environmental tracers. The Quik Combo expired pads were immediately discarded and replaced. A memo was posted for staff December 11, 2013, noting ISDH hospital and unit survey deficiencies, with reminder to check expiration date of the Quik combo pads with the daily AED check. Reminder note was placed on the AED check-off board on January 2, 2014. The Director of	

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	<p>3. During the tour of the same day surgery area at 9:45 AM on 12/03/13, accompanied by staff members A11 and A13, the accucheck control solutions for the glucometer were observed with a discard date of 11/30/13.</p> <p>4. During the tour of the surgical area at 11:00 AM on 12/03/13, accompanied by staff members A12 and A13, the following items were observed in the Malignant Hyperthermia kit: A. One of two packages of sterile gauze sponges with an expiration date of 11/13. B. One of three sterile catheters with an expiration date of 11/13. C. One of three sterile Toomey syringes with an expiration date of 11/13. A handwritten sheet on the outside of the kit indicated these items expired along with some lab tubes which were not found in the kit.</p> <p>5. During the tour of the Pediatric unit at 1:35 PM on 12/03/13, accompanied by staff members A13 and A16, a large cardboard box from the outside was observed stored with clean items in the</p>		Mental Health and the Executive Director of Emergency Services will ensure compliance. risk Management and Accreditation will follow-up with environmental tracers.		

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	<p>supply room.</p> <p>6. During the tour of the Neonatal Intensive Care Unit at 2:35 PM on 12/03/13, accompanied by staff members A13 and A16, a large cardboard box from the outside was observed stored with clean items in the supply room.</p> <p>7. During the tour of the Labor and Delivery area at 3:10 PM on 12/03/13, accompanied by staff members A13 and A17, three cardboard boxes from the outside were observed stored with clean items in the supply room.</p> <p>8. During the tour of the Nursery at 3:45 PM on 12/03/13, accompanied by staff members A13 and A17, a cardboard box containing a carseat from the outside was observed stored with clean items in the supply room.</p> <p>9. During the tour of the Post-Partum Unit at 4:00 PM on 12/03/13, accompanied by staff members A13 and A17, a large cardboard box from the outside was observed stored with clean items in the supply room. Two cabinets in the medication room were observed containing two of two BacT/Alert anaerobic culture bottles with an expiration date of 04/10/13 and 04/26/13</p>			

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	<p>and three of three bags of intravenous fluid, one with an expiration date of Oct. 1, 2012 and two with an expiration date of Nov. 1, 2013.</p> <p>10. During the tour of the Endoscopy area at 10:35 AM on 12/04/13, accompanied by staff members A12, A13, and A18, a thirty milliliter vial of bacteriostatic water with an expiration date of 1 May 2013 was observed in a cabinet in the storeroom.</p> <p>11 During the tour of the Mental Health unit at 11:15 AM on 12/04/13, accompanied by staff members A13 and A23, one of two packages of Quik-Combo pads with an expiration date of 11/28/13 was observed stored with the AED.</p> <p>12. During the tour of 6 West at 2:40 PM on 12/04/13, accompanied by staff members A26 and A30, a cardboard box from the outside was observed stored with clean items in the supply room.</p> <p>13. At 11:00 AM on 12/03/13, staff member A12 indicated the emergency cart, malignant hyperthermia kit, and other storage areas were checked monthly for outdated medications and supplies.</p>						

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S000598	<p>14. At 11:05 AM on 12/03/13, staff member A14 indicated the pharmacy staff only checked medications, and not supplies, on any of the emergency carts for outdates.</p> <p>15. At 3:30 PM on 12/04/13, staff member A13 confirmed the outside cardboard boxes should not be stored with clean supplies.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure the Ultrasound Gel containers are properly disinfected</p>	S000598	This correction of deficiency includes items 1 through 4. The practiced has been changed to dispose of the gel bottle when empty for all radiology departments, inpatient and off-site. New bottles will be filled	01/06/2014

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	<p>before they were refilled with Liquid Sonic Ultrasound Gel located in the Radiology Department Ultrasound room and Northpoint Rehab Services.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. FDA indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. However, past studies have demonstrated that ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA recommends that Ultrasound Gel containers not to be refilled.</li> <li>2. At 10:05 AM on 12/4/2013, the Radiology Department Ultrasound room was inspected. Located in the room was a table with 16-ounce ultrasound gel containers. The containers were</li> </ol>		<p>with gel each time. This process is in place. It began January 6, 2014. The Manager of Radiology and the Executive Director of Ambulatory Operations will ensure compliance. This has been added to all Radiology department tracers, inpatient and off-sites. Risk Management and Accreditation will follow-up with these tracers.</p>	

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	<p>filled from a bulk plastic container of Liquid Sonic Ultrasound Gel. The room does not have any sterile processing for the gel containers before they are refilled.</p> <p>3. At 8:40 AM on 12/4/2013, Northpoint Rehab Facility was inspected. The ultrasound jell bottles are refilled and the labels on the bottles gave the appearance of been used over and over again. The labels were deteriorating.</p> <p>4. At 10:10 AM on 6/12/2013, staff member #L21 indicated he/she refills the ultrasound gel plastic bottles without sterilizing and/or disinfecting the containers before they are refilled.</p>			

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S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on documentation review, observation, and interview, the hospital kitchen staff did not wash their hands as required by state law, 410 IAC 7-24-129 and the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. The contract between the foodservice and St. Mary's Medical Center of Evansville was</p>	S000608	This correction of deficiency includes items 1 through 7. The Food Service staff was in-serviced on December 20, 2013 and January 6, 2014 on hand washing requirements, food temperature requirements, and general sanitation requirements. Monthly in-services are held for Food Service staff. These topics will be included in the monthly presentations. The staff periodically check the food temperatures for compliance. Weekly Infection Control audits will be performed, including hand washing, food temperatures and general sanitation. The target goal is greater than 90%. TSS In-Service Training Manual, department orientation checklists, and logs are to be maintained in	01/06/2014

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	<p>approved 2013. The contract shall adhere to all local, state, and Federal rules and regulations.</p> <p>2. 410 IAC 7-24-129, When to Wash Hands: Food employees shall clean their hands and exposed portions of their arms as specified under section 106 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: After touching bare human body parts other than clean hands and clean, exposed portions of arm; After coughing, sneezing, or using a handkerchief or disposable tissue; After handling soiled surfaces, equipment, or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with raw food and working with ready-to-eat</p>		<p>Director of Food and Nutrition Services office to monitor compliance. This is included in the monthly Infection Control Surveillance audits. This target goal is greater than 90%. The Director of Food and Nutrition Services and the Vice President of Clinical and Ancillary Services will ensure compliance. Monthly Infection control audits, performed by the Infection Preventionist, will be communicated to Risk Management and Accreditation for follow-up. Regarding the surgical mask issue, on January 16, 2014, the issue was discussed in Surgery Report and posted signage in appropriate locations with the following information:-Masks are to be discarded after each procedure. -Masks are not be worn around the neck. The above is per AORN Standards and Recommendations, 2013. Recommendation V: VI.b.1. &amp; V.I.c. The Director of Surgery or her designee will assure this protocol is being followed. If needed, noncompliant OR staff will receive counseling. If noncompliance occurs with staff not under the jurisdiction of the Director of Surgery, she will notify that staff person's supervisor to follow-up with the staff person. The Director of Surgery, Director of Post-Anesthesia Care Unit/Same Day Surgery, and the</p>				

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	<p>food; Before touching food or food-contact surfaces; Before placing gloves on hands; After engaging in other activities that contaminate the hands.</p> <p>3. At 10:15 AM on 12/3/2013, three staff working on the Patient Service Line were observed multiple times changing their gloves without washing their hands in between the changing of the gloves. One staff member, who was working at the fry station of the Patient Service Line, was observed placing raw pork cutlets on the grill with his/her bare hands then followed-up putting on single-use gloves without washing his/her hands first. A supervisor told him/her to retrieve something from dry storage and the staff member did not put on the gloves. However, the box of gloves on the prep table was already touched by the staff member's hands that touched the raw pork cutlet.</p> <p>4. During the tour of the surgical areas, same-day surgery, post-anesthesia care</p>		<p>Executive director of Perioperative Services will ensure compliance within the perioperative areas. If there is a physician compliance issue, the Chief of Surgery or Vice President of Medical Affairs will be notified and will be responsible for ensuring compliance.</p>		

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	<p>unit, and hallways, between 10:00 AM and 12 noon on 12/03/13, and accompanied by staff members A11, A12, and A13, ten different staff members were observed walking in and out of the areas with surgical masks hanging around their necks, including one with the mask slid around to the back of the neck.</p> <p>5. The facility policy "Dress Code (Operating Room)", effective 05/12/11, indicated, "4. Masks will be removed and discarded whenever leaving the Operating Room Suites or when soiled or wet." The policy referenced AORN Standards.</p> <p>6. At 12:15 PM on 12/03/13, staff member A12 confirmed the surgical area followed AORN guidelines.</p> <p>7. At 4:15 PM on 12/03/13, staff member A13 confirmed the facility's policy indicated the masks were to be removed when leaving the OR Suite.</p>			

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S000610	<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 documentation review, observation, and staff interview, the hospital failed to cook raw hamburger and raw chicken to the required cooking temperature that was going to be served to patients.</p> <p>Findings included:</p>	S000610	This plan of correction for deficiency includes items 1 through 5. The Food Services staff was in serviced on December 20, 2013 and January 6, 2014 on hand washing requirements, food temperature requirements, and general sanitation requirements. Monthly in-services are held for Food Service staff. These topics will be included in the monthly	01/06/2014			

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	<p>1. The contract between the foodservice and St. Mary's Medical Center of Evansville was approved 2013. The contract specifies that the contacted foodservice company will provide food to the patients cooked at the proper temperatures. The contract shall adhere to all local, state, and Federal rules and regulations.</p> <p>2. 410 IAC 7-24-182 Cooking of Raw Animal Foods: Raw animal foods, such as eggs, fish, meat, poultry, and foods containing these raw animal foods, shall be cooked to heat all parts of the food to a temperature and for a time that complies with one (1) of the following methods based on the food that is being cooked: One hundred fifty-five (155) degrees Fahrenheit for fifteen (15) seconds for Comminuted meat or fish; One hundred sixty-five (165) degrees Fahrenheit or above for fifteen (15) seconds for poultry, game</p>		<p>presentations. The staff periodically check the food temperatures for compliance. Weekly Infection Control audits will be performed, including hand washing, food temperatures and general sanitation. The target goal is greater than 90%. Monthly Infection Control audits performed by the Infection Preventionist must meet a target of greater than 90%. The Director of Food and Nutriion Services and Vice President of Clinical and Ancillary Services will ensure compliance. The results of the monthly Infection Control audits performed by the Infection Preventionist will be mailed to Risk Management and Accreditation for follow-up.</p>				

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	<p>animals, stuffed fish, stuffed meat, stuffed pasta, stuffed poultry, or stuffing containing fish, meat, or poultry.</p> <p>3. At 10:30 AM on 12/3/2013, the fry station was observed with two 4-inch deep pans on the grill containing grilled chicken breast in on container and grilled hamburger patties in the other. Each container contained at least 20 hamburgers or chicken breasts in their containers. Each container had about 1-inch of water in the pan. Both products were stacked above the water level within the pan. The chicken breast registered between 118 to 127 degrees Fahrenheit. The water temperature in the pan registered 135 degrees Fahrenheit. The container of hamburger registered between 112 to 119 degrees Fahrenheit. The water within the pan of hamburger registered 120 degrees Fahrenheit. Both items were cooked from raw.</p>			

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	<p>4. At 10:45 AM on 12/3/2013, the fryers located adjacent to the Patient Service Line's grill were observed with French fries in one basket and breaded fish squares in the other basket. Both items had been deep fried and were draining above the hot grease for at least 15 minutes. There were at least 25 deep fried fish squares in one of the fryer ' s baskets. One fish square tempted at 119 degrees Fahrenheit.</p> <p>5. At 11:00 AM on 12/3/2013, staff member #4 confirmed the staff did not properly cook the chicken and the hamburger on the grill at the Patient Service Line.</p>			

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and staff interview, the facility failed to ensure orders were followed for physician notification for 1 of 3 general medical patients.</p>	S000912	This plan of correction includes items 1 and 2. For all of the Medical inpatient departments: The conditional orders (PRN) written by the physicians,	01/06/2014			

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	<p>Findings include:</p> <p>1. Review of patient #9 medical record indicated the following: (A) An order was written at 2320 on 7/10/13 to call the physician if the patients temperature was &gt;101. (B) The medical record indicated that the patients temperature was 101.6 at 2010 on 7/16/13, 101.3 at 2321 on 7/16/13, 101.9 at midnight on 7/16/13, 101.5 at 2219 on 7/17/13. The medical record lacked documentation that the physician was notified of the increased temperature per order.</p> <p>2. Staff member #N1 verified the above beginning at 12:00 p.m. on 12/5/13.</p>		<p>related to notification and medication administration has been discussed and will continue to be presented at staff meetings and daily huddles in January, 2014. The staff will review the January Focus on CARE which includes education on these issues. Follow-up audits will be performed beginning in February, 2014 and continue until 90% compliance is met. Compliance issues will be addressed with the appropriate staff member. The Directors of the Clinical departments and the Executive Director of the Medical-Srugical Departments will ensure compliance. The audit results will be provided to Risk Management and Accreditation for follow-up.</p>		

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S000946	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(4)</p> <p>(c) Drugs and biologicals shall be prepared for administration and administered as follows:</p> <p>(4) In accordance with the signed written orders of the practitioner or practitioners responsible for the patient's care. When verbal or telephone orders are used they shall be accepted only by personnel that are authorized to do so by the medical staff rules.</p> <p>Based on document review and staff interview, the nursing staff failed to follow physician orders for 1 of 3 general medical patients and 3 of 9 intensive care patients.</p> <p>Findings include:</p> <p>1. Facility policy titled "STAT ORDERS" states under definitions: "A. STAT order- an order for medication needed within 20 minutes of being ordered by the physician." and under Procedure, the policy states: "B. When the pharmacy receives a properly marked STAT order, the order will automatically be placed at the top of the work queue in pharmacy and handled as a priority order....."</p> <p>2. Review of patient #5 (intensive care</p>	S000946	<p>This plan of correction includes items 1 through 6. For all of the Medical inpatient departments:</p> <p>In regards to noncompliance with conditional MD orders (PRN) related to notification and medication administration: Education was presented at staff meetings and daily huddles in January 2014. The staff will be required to review the January Focus on CARE which includes education on these issues. Follow-up audits will be performed beginning in Feb. 2014 and continue until 90% compliance is met. Compliance issues will be addressed with the appropriate staff member. In the Intensive Care Units (ICU), the clinical supervisors have discussed the range order, stat order and physician's conditional orders (PRN) related to notification and medication</p>	01/31/2014			

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	<p>patient) medical record indicated the following:</p> <p>(A) An order was written at 1440 on 6/11/13 for Rocephin stat. The medication was not administered until 1636 on 6/11/13.</p> <p>(B) An order was written at 1645 on 6/11/13 for Zosyn stat. The medication was not administered until 1825 on 6/11/13.</p> <p>3. Review of patient #6 (intensive care patient) medical record indicated the following:</p> <p>(A) An order was written at 2100 on 5/31/13 for Vancomycin stat. The medication was not administered until 2209 on 5/31/13.</p> <p>4. Review of patient #9 (general medical patient) medical record indicated the following:</p> <p>(A) An order was written at 1636 on 7/11/13 to administer Tylenol 650 mg every 6 hours as needed for increased temperature</p> <p>(B) An order was written at 1147 on 7/18/13 to administer Clonidine .1 mg twice daily as needed if the patients systolic blood pressure (SBP) was &gt; 160.</p> <p>(C) The medical record indicated that the patients temperature was 101.6 at 2010 on 7/16/13, 101.3 at 2321 on</p>		<p>administration compliance findings in the shift safety huddles the week of January 6-10, 2014. The Executive Director of the Critical Care Units has placed a hard copy of the memo, the January Focus on Care, which includes education on these findings, and newly developed audit tools in the Clinical Supervisors Office. Follow-up audits will be performed. Compliance issues will be addressed with the appropriate staff member. The audits will be performed until 90% compliance is met. The Executive Director of the Critical Care departments and the Executive Director of the Medical Surgical departments will ensure compliance. The audit results will be provided to Risk Management and Accreditation for follow-up.</p>				

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	<p>7/16/13, 101.9 at midnight on 7/16/13, 101.5 at 2219 on 7/17/13. The patient did not receive Tylenol per order.</p> <p>(D) The Clonidine was not administered per order. The patients blood pressure was 172/82 at 2142 on 7/18/13, 162/82 at 1819 on 7/20/13, 164/72 at 2036 on 7/21/13, 168/84 at 12 noon on 7/23/13, and 161/76 at 0540 on 7/24/13 with no Clonidine administered. Additionally, the patient received the Clonidine at 0959, 1507, and 2116 on 7/22/13 when the SBP was not &gt; 160. The Clonidine was administered at 10:15 a.m. and 1721 on 7/23/13 when the SBP was not &gt;160.</p> <p>5. Review of patient #20 (intensive care patient) medical record indicated the following: (A) An order was written at 1515 on 7/18/14 for Vancomycin stat. The Vancomycin was not administered until 1750 on 7/18/13.</p> <p>6. Staff member #N1 verified the above information beginning at 12:00 p.m. on 12/5/13.</p>				

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S001014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on observation, interview, and policy and procedure review, the facility failed to follow its pharmacy policy regarding multidose medications and failed to ensure adequate storage and monitoring of medication.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. During the tour of the operating suite at 12:05 PM on 12/03/13, accompanied by staff members A12 and A13, an open, but not dated, 20 milliliter vial of 1% Lidocaine was observed ready for use on a tray stand with packaged syringes.</li> <li>2. At 12:05 PM on 12/03/13, staff member A12 indicated the vial should have been dated when opened.</li> <li>3. During the tour of the labor and delivery area at 3:10 PM on 12/03/13, accompanied by staff members A12,</li> </ol>	S001014	<p>This plan of correction includes items 1 through 9.Regarding the discarding of multidose vials, the Surgery staff have been educated to discard multi-dose vials at the end of each procedure. An e-mail was sent to all RN Surgery staff on December 30, 2013 by the Director os Surgery and discussed in daily report on December 30, 2013. Rooms will be periodically audited for opened multidose vials. If found, follow-up with accountable staff person will occur by the Director of Surgery or the Charge Nurse. The Director of Surgery and the Executive Director of Perioperative Services will ensure compliance.The labor and delivery staff have been instructed by Pharmacy staff regarding prompt return of discontinued or discharged patient medications and use of multi-dose expiration dating sticker for any floor stock multi-dose vials. Because patient meds are not stored within the</p>	01/06/2014			

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	<p>A13, and A17, an open, but not dated, five milliliter vial of Betamethasone was observed in a cabinet in the medication room. Two other open vials of Betamethasone, labeled for specific patients, were also stored in the cabinet with other supplies. The patients were no longer admitted to the facility.</p> <p>4. At 3:10 PM on 12/03/13, staff member A17 indicated the vial should have been dated when opened. He/she also indicated the patient specific vials should have been stored in the locked cabinet in the patient's room, then discarded when the patient was discharged.</p> <p>5. During the tour of the Post-Partum unit at 4:00 PM on 12/03/13, accompanied by staff members A13 and A17, a medication cart was observed unlocked and unattended in the 3100 hall.</p> <p>6. During the tour of patient unit 5 South at 1:15 PM on 12/04/13, accompanied by staff members A26 and A27, an open, but not dated, one milliliter vial of Tubersol solution for TB testing was observed in the medication refrigerator. Residual white powder was also observed in a pill crusher that was ready for use in a</p>		<p>Pyxis, they do not have their expiration dates tracked through the Pyxis software. The department Director has reinforced this education during safety huddles through the Charge nurse in December, 2013. The Charge nurse has been assigned to check the medication rooms, where the discharged patient medications are kept. If found, follow-up with accountable staff person will occur by the OR Director or the Charge Nurse. The Director of Labor and Delivery and the Executive Director of Perioperative Services will ensure compliance. Regarding medication security, the Director of Post-Partum provided follow-up with the staff after the surveyor's visit. The Post-Partum charge nurses presented the information in the daily huddles in December, 2013. The charge nurses will perform daily random checks and follow-up with addressing unsecured medication issues directly with the responsible staff member. The Director of Post-Partum and the Executive Director of Perioperative Services will ensure compliance. Regarding expired medication on 5 South. All floor stock meds stored in Pyxis have the expiration dates recorded in the software. The Pharmacy runs regular reports to track and remove expired or soon to be expired meds. The Tubersol on 5</p>				

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	<p>medication cabinet.</p> <p>7. At 1:15 PM on 12/04/13, the nurse in the medication room indicated a sticker should be on the vial and the discard date written in, but the blank sticker was in the vial's box.</p> <p>8. The facility policy "Supply and Product Expiration", effective 05/12/11, indicated, "D. Multi-Dose Vials with Preservatives (not insulin or vaccine): The BUD [beyond use date] after initially entering or opening a multi-dose container is 28 days unless otherwise specified by the manufacturer. Use within 28 days if properly stored, not contaminated, and manufacturer does not specify a shorter expiration date. 1. The healthcare worker initially opening or entering the multi-dose container will be responsible for placing an expiration label on the container. 2. The healthcare worker will obtain a green expiration label that states 'Multi-Dose Vials Expire 28 Days After Opened. This Vial Expires On ____.' The healthcare worker will place this label on the opened vial with the new expiration date recorded on the label."</p> <p>9. The facility policy "Medication: Medication Storage Area Inspection", effective 09/18/11, indicated, "2. Drugs</p>		<p>South was set up as a floor stock medication, so it was missed being checked. Tubersol will no longer be kept on 5 South. The Tubersol solution has been removed. Staff will call pharmacy when patient needs to have TB skin test. After administration of TB skin test, the Tubersol will be immediately sent back to pharmacy. The Director of 5 South and the Executive Director of the Medical Surgical departments will ensure compliance. All RNs in the Department are required to read the policy, "Medication: Oral Tablet Splitting and Crushing" and sign to validate they have read it. The Clinical Supervisors have discussed during daily huddles in December, 2013. An e-mail was sent to all 5 South RNs regarding correct procedure and protocols to meet compliance on expired Tubersol and cleaning of the pill crusher on January 3, 2014. The pill crusher will be audited monthly by the Clinical Supervisors for compliance of cleaning. The Director of 5 South and the Executive Director of the Medical Surgical departments will ensure compliance. All audit results will be provided to Risk Management and Accreditation for follow-up.</p>				

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S001024	<p>will be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. 3. Properly controlled drug preparation areas will be designated, and locked medication carts and/or PYXIS Medstations will be provided for each nursing unit as required. ...5. Medication carts and controlled drug compartments are locked."</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 observation and document review, the hospital failed to follow hospital policy to store outdated drugs in a separate area from general inventory in 1 instance.</p> <p>Findings:</p>	S001024	This plan of correction includes items 1 and 2.Regarding Pharmacy outdates, various staff members have been assigned sections of the department to check for outdates. Each section will be checked quarterly. Note – this is in addition to the outdate check upon dispensing that is	01/06/2014

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	<p>1. On 12-3-13 at 3:05 pm, in the presence of employee #A10, it was observed in the main Pharmacy current drug use storage area there were 20 each unit dose packages of 2 mg capsules of Prozosin HCl. Each package had an expiration date of 11-30-13.</p> <p>2. Review of a hospital Document # 100560, entitled MEDICATION: MEDICATION STORAGE AREA INSPECTION (General Hospital), indicated Outdated or otherwise unusable drugs will be identified and returned to the Pharmacy for proper disposition.</p> <p>The Director of the Pharmacy department designates one or more areas for the authorized storage of such drugs prior to their proper disposition. These drugs are stored outside the buyer's office in the pharmacy prior to disposal.</p>		<p>performed by the pharmacist. A sign-off grid has been developed and posted for tracking and documentation purposes. The "Medication Storage Area Inspection" policy and procedure was updated to incorporate this change. The Director of Pharmacy and the Vice President of Clinical and Ancillary Services will ensure compliance.</p>		

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S001118	<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 documentation review, the facility failed to maintain the Production Kitchen in a sanitaty manner and created conditions which resulted in a hazard to employees in 2 instances (gas storage area and maintenance shop).</p> <p>Findings included:</p> <p>1. The contract between the foodservice and St. Mary's Medical Center of Evansville was approved 2013. The contracted company indicated they will maintain a sanitary environment which includes clean equipment, floors, walls, ceilings, etc. The contract shall adhere to all local,</p>	S001118	<p>This plan of correction includes items 1 throught 8: The Food Service staff was in-serviced on December 20, 2013 and January 6, 2014 on hand washing requirements, food temperature requirements, and general sanitation requirements. Monthly in-services are held for Food Service staff. These topics will be included in the monthly presentations. The staff will periodically check the food temperatures for compliance. Weekly Infection Control audits will be performed, including hand washing, food temperatures and general sanitation. The target goal is greater than 90%. Results of monthly Infection Control audits performed by the Infection Preventionist will be sent to the Vice President of Clinical and Ancillary Services and e-mailed to Risk Management and Accreditation for review and follow-up if compliance issues</p>	01/06/2014			

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	<p>state, and Federal rules and regulations.</p> <p>2. Review of St Mary's Infection Control Committee meetings between 1/2/2013 and 7/3/2013 indicated the Infection Control Committee met once a month and Food Service was discussed in each meeting. Each committee meeting identified that the department had sanitation issues to address.</p> <p>3. At 9:40 AM on 12/3/2013, the Patient Serving Line in the Production Kitchen was inspected. The floor surfaces under the kitchen equipment and the serving line were observed with heavy accumulation of food debris and other soil residue. The floor was greasy to touch. Three of three red sanitizing wiping cloth containers that are used to wipe food-contact surfaces registered less than 100 parts per million quaternary ammonia. The manufacturer requires the</p>		<p>noted. The Director of Food and Nutrition Services and the Vice President of Clinical and Ancillary Services will ensure compliance. All kitchen floors were pressure washed. All department job flows are to include required cleaning duties. The department managers or an assigned delegate are to validate completion daily on the cleaning assignment sheets. Logs are to be maintained by department managers to validate completion. Employees failing to complete assignments should be coached or counseled as appropriate. In-service with staff occurred on December 20, 2013 and January 6, 2014. Monthly in-services are held for Food Service staff. These topics will be included in the monthly presentations. All control measures are to be maintained and monitored daily by the Director of Food and Nutrition Services. Logs are to be maintained in Director of Food and Nutrition Services' office to monitor compliance. Infection control audits will be used as a monthly measure of compliance and progress. The Director of Food and Nutrition Services will report to the Ancillary Quality and Patient Safety Committee. Appropriate action plan will be submitted for areas of non-compliance. Weekly infection control audits will be completed with a target of greater</p>		

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	<p>concentration to be between 150 and 400 parts per million quaternary concentration for it to be effective against bacteria that can contribute to a food borne infection.</p> <p>4. At 10:00 AM on 12/4/2013, the sanitation of the Production Kitchen was inspected. The Patient Service Line was observed with soiled rags stored on prep tables and on shelves under the prep tables. The soiled rags were wet and they were not observed on 12/4/2013. The Patient Service Line floor was heavily soiled with food debris on it.</p> <p>5. At 10:30 AM on 12/4/2013, the food production area was observed with the floor heavily soiled with loose food deposits. One lower shelf of one of the prep tables was observed rusty with loose food on the shelf. The exterior surfaces of the cooking equipment were observed greasy with accumulation of soil residue</p>		<p>than 90%. Results of monthly Infection Control audits performed by the Infection Preventionist will be sent to the Vice President of Clinical and Ancillary Services and e-mailed to Risk Management and Accreditation for review and follow-up. The Director of Food and Nutrition Services and the Vice President of Clinical and Ancillary Services will ensure compliance. The Food Service staff was in-serviced on December 20, 2013 and January 6, 2014 on fire safety (items being placed near heat sources). Monthly in-services are held for Food Service staff. This topic will be included in the monthly presentations. The binders were removed immediately and placed on the correct bookshelf within the department. The pan of black water had been temporarily placed by a plumber who was working on an issue. It was removed, cleaned, and replaced immediately. It was removed and disposed of as soon as the repair was completed. The Food and Nutrition Services Director, the Facilities Director, and the Vice President of Clinical and Ancillary Services will be responsible for supervision during repairs in the department and ensure compliance. Regarding tanks in the tank storage area, the unsecured tanks were immediately secured in place with a tank holder. This was</p>		

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	<p>on them. Under the steam jacket kettles, there was a pan under a drain pipe collecting drips from the pipe. The pan was filled with black water. The floor behind the cooking equipment was observed heavily soiled with dirt and food. The industrial stove was observed storing assorted paper manuals and binders. The stove was observed operational and the threat of a fire exists storing papers adjacent to gas burning stove.</p> <p>6. On 12-3-13 at 11:20 am in the presence of employee #A10, it was observed in the gas storage area, there were 2 small tanks on the floor unsecured by chain or holder.</p> <p>7. On 12-3-13 at 12:20 pm in the presence of employee #A10, it was observed in the maintenance shop, there was 1 small argon tank on a mobile cart that was insufficiently secured by chain or holder.</p>		<p>communicated to the Director of Facilities responsible for the area. It was shared with the staff the week of December 9, 2013. This will be on our hospital environmental tracers. Risk Management and Accreditation will perform tracers as follow-up. The Director of Facilities and the Vice President of Clinical and Ancillary Services will ensure compliance. Regarding tanks in the maintenance shop, the argon tank was immediately secured in a holder on December 3, 2013. Education on proper storage of pressurized tanks was presented with the maintenance staff. in December, 2013. The Director of Facilities and the Vice President of Clinical and Ancillary Services will ensure compliance. This will be on our hospital environmental tracers. Risk Management and Accreditation will perform tracers as follow-up.</p>				

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(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	
S001150	<p>8. 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>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 2 instances.</p> <p>Findings:</p> <p>1. On 12-3-13 at 10:55 am in the presence of employee #A10, it was observed in the shower of Room 2923 there was a flexible hose connected to a</p>	S001150	This plan of correction includes items 1 and 2: Regarding the backflow prevention devices and flexible hoses, the Facilities Director scheduled correction of this issue. Backflow prevention devices were placed in all showers where needed in the Rehabilitation building. All showers in the hospital are currently being checked and will be corrected by the end of January, 2014. The Director of Facilities and the Vice President of Clinical and Ancillary Services will ensure compliance.	01/31/2014	

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S001164	<p>water spigot without a backflow prevention device.</p> <p>2 On 12-3-13 at 11:20 am in the presence of employee #A10, it was observed in the shower in the Rehab facility there was a flexible 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(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 documentation review and staff interview, the facility failed to ensure documented evidence that the Nurse Call Systems had preventive maintenance conducted.</p> <p>Findings included:</p>	S001164	This plan of correction includes items 1 and 2:Regarding the periodic maintenance (PM) on the Nurse Call System, the Director of Facilities has contacted two vendors for quotes. A decision will be made in January, 2014 and the periodic maintenance will be placed on an annual schedule. The Facilities Director will maintain a log of the	03/01/2014			

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	<p>1. The facility could not provide documentation that the Nurse Call Systems have been monitored for their preventive maintenance.</p> <p>2. At 1:45 PM on 12/5/2013, staff member #L10 indicated the Nurse Call Systems have never been identified to be on a preventive maintenance schedule; therefore, the Nurse Call systems have never been documented as being inspected for preventive maintenance.</p>		<p>PMs on the Nurse Call System. The Director of Facilities and the Vice President of Clinical and Ancillary Services will ensure compliance.</p>		

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S001172	<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 observation, the facility failed to maintain the Morgue shower/restroom in a sanitary manner.</p> <p>Findings included:</p> <p>At 11:45 AM on 12/5/2013, the Morgue was inspected. The shower stall was observed with heavy accumulation of lime and other soil residue on the tile walls and the shower floor. The bar of soap in the shower was observed with grime on it. The restroom</p>	S001172	Plan of correction: The Quality Improvement Lab Manager had the items (boxes) removed from the floor in the restroom. General cleaning of the shower and restroom was completed by the Pathology staff. As it is rarely used, the shower and restroom will be checked and maintained monthly by Pathology. The Environmental Services Director has agreed to have Environmental Service staff check the morgue weekly and mop the floor in the shower and restroom of the morgue, as needed. The Director of Pathology and the Vice President of Clinical and Ancillary Services will ensure compliance.	01/10/2014			

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	floor was heavily caked with soil residue on the tile floor and items were also observed stored on the floor and not off the ground to prevent easy cleaning.			