STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150006	A. BUILDING 00 B. WING	11/29/2012

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INDIANA UNIVERSITY HEALTH LA PORTE HOSPITAL	1007 LINCOLNWAY LA PORTE, IN 46350

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S0000	This visit was for a standard licensure survey. Facility Number: 005006 Survey Date: 11/26, 27, 28 & 29/2012 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor Lynnette Smith, Medical Surveyor QA: claughlin 12/10/12	S0000	Response to summary statement of deficiencies from survey conducted 11/26 - 11/29/2012 will be submitted today (12/19/2012.)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S0178	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 facility failed to post the hospital license in an area conspicuous and open to patients and the public in 4 of 4 instances. Findings: 1. On November 27, 2012 at 1:45pm, at the Lifeworks Vascular Center offsite area, and in the presence of Employee #A4, it was observed that there was no posting of the hospital license. 2. On November 27, 2012 at 2:15pm, at the Lifeworks Imaging offsite area, and in the presence of Employee #A4, it was observed that there was no posting of the hospital license. 3. On November 27, 2012 at 3pm, at the Lifeworks Rehab offsite area, and in the presence of Employee #A4, it was observed that the posted hospital license had expired on June 30, 2006.	S0178	1. 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **CV Lifeworks** **S178** License posted in **CV Lifeworks** 3777 North Frontage Road Michigan City, IN46360 Cardiac testing Suite 500 Date of Correction 11/30/2012 **Wellness and Rehab** **S178:** Posting Hospital License - **Wellness and Rehab** As of 12/13/2012 all Wellness and Rehab facilities have current Hospital License appropriately posted. Director Frank Aerts oversaw the assessment and posting of current hospital license in an area in each wellness and rehab facility that was conspicuous and open to patients and the public. Outpatient Wellness and Rehab Facilities: 1855-2143681 The Crossing Wellness and Rehab	12/13/2012

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	4. On November 28, 2012 at 10:30am, at the Hospital and Health services Wellness Center offsite area, and in the presence of Employee #A16, it was observed that there was no posting of the hospital license.		1203 Washington St. La Porte, In 46350 LifeWorks Wellness and Rehab 3777 North Frontage Road,Suite 100 Michigan City, In 46360 New Carlisle Wellness and Rehab 8988 East US Hwy 20 New Carlisle, IN 46552 Playtime Pediatrics - Founders Square 1509 State St. La Porte, IN 46350 Sagamore Wellness and Rehab 600 Legacy Plaza La Porte, IN 46350 Westville Wellness and Rehab 156 North Flynn Road Westville, In 46391 **LifeWorks Diagnostic Imaging** **S178** –State License not posted in public area. License posted on 11/27/12 in an area visible to patients and the public. Heidi Jankowski, administrative assistant, has been educated by Pauline Arnold, 11/30/12, Chief Nursing / Quality officer that when the hospital receives a new License it is to be forwarded to all off site facilities that fall under the license. Heidi will ask for a return receipt	

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			that facility received license and that it was posted in a conspicuous place open to patients and the public. 2. How are you going to prevent the deficiency from reoccurring in the future? **CV Lifeworks** **S178** Ensure that license is valid and visible Environment of care performs rounds. I will make the recommendation that it get added to EOC Rounds I will have my Patient Safety officer, Doug Hynek check quarterly with safety rounds, and report back to me. **Wellness and Rehab** **S178:** Posting Hospital License Posting of current Hospital License will be checked monthly during facility rounding by an assigned supervising colleague, Assistant Director. **LifeWorks Diagnostic Imaging** License holder permanently posted in public / patient area. Cannot be removed. 3. Who is going to be responsible for 1 and 2 above, include name and title. **CV Lifeworks**	

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			S178 Mary Drewes, Director of Cardiovascular Services Doug Hynek, Clinical Team leader **Wellness and Rehab** **S178:** Posting Hospital License Nicole Springer, Assistant Director Wellness and Rehab Services Becky Alwood, Assistant Director Wellness and Rehab Services Judy Trumble, Assistant Director Wellness and Rehab Services Frank Aerts, Director Wellness and Rehab Services. **LifeWorks Diagnostic Imaging** Dennis R. Gumbert, PhD, Director, Diagnostic Imaging/Women's Imaging/LifeWorks Imaging 4. By what date are you going to have the deficiency corrected? **CV Lifeworks** S 178 Completed on 11/30/12 **Wellness and Rehab** **S178:** Posting Hospital License 12/13/2012 **LifeWorks Diagnostic Imaging** Deficiency corrected 11/27/12 (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.** (B) If the deficiency cannot be completed within 30 days the Plan	

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			of Correction must be written in incremental 30 day phases.	

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S0332	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L) (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: (L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures. Based on observation, policy and procedure review, and staff interview, the chief executive officer failed to ensure personnel competency in fulfilling responsibilities and verifying inservicing in decontamination procedures for 1 of 11 (Emergency Department {ED}) areas toured. Findings: 1. While on tour of the ED on 11/27/12 at approximately 11:35 AM, in the company of P30, P31, and P32, staff (P30 and P33) were asked to explain the procedure for delivering care in the event of a large scale exposure requiring decontamination and were unable to explain the details of the procedure.	S0332	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. 1.Update the Decontamination Policy (ADM-IC-032) 2.Re-establish the Code Orange Team 3.Provide Training to Code Orange Team 1.Establish annual training for Code Orange Team 2.Establish an annual Code Orange drill/exercise 4.Establish a process for recruitment of new Code Orange members when members leave the team 2. How are you going to prevent the deficiency from reoccurring in the future?	02/28/2013

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	2. Policy No.: ADM-IC-032 titled, "Bioterrorism Readiness Plan" with an effective date of 8/30/10 was reviewed on 11/29/12 at approximately 9:48 AM, and indicated on pg.: A. 4, under Post Exposure Management section, point 3., "Triage and management of large scale exposures and suspected exposures - Each healthcare facility, with involvement of the IC (Infection Control) committee, administration, building engineering staff, emergency department, laboratory directors and nursing directors, should clarify in advance how they will best be able to deliver care in the event of a large scale exposure..." B. 5, under Post Exposure Management section, point 4., "Provide bioterrorism readiness education, including frank discussions of potential risks and plans for protecting healthcare providers." 3. Personnel P32 was interviewed on 11/27/12 at approximately 11:55 AM and confirmed there has been some recent turn over of ED staff and training for the decontamination process has not been done for over a year. This training should be done at least annually.		1. Update and review policy annually (1 st quarter annually) 2. Recruitment of Code Orange Team members when members leave the team. Unit Director of the Emergency Department will assign a new member to the Code Orange Team when a currently assigned team member resigns, transfers, or is terminated. 3. Annual training and drill established (1 st quarter annually) 3. Who is going to be responsible for 1 and 2 above, include name and title. 1. Terry Rhoda Emergency Management Coordinator 2. Patti Navarro Executive Director of Critical Care Services 4. By what date are you going to have the deficiency corrected? 1. Within 30 days (12/29/12) the policy will be reviewed andupdated. An Annual review of the policy will occur within the 1Q of every year. 2. Within 30 days (12/29/12) the new Code Orange team members will be identified 3. Code Orange Training will be scheduled within 60 days (1/29/13) and completed within 90 days (2/28/13) 4. Within 30 days (12/29/12) the process for recruitment of Code	

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			Orange team members will be completed (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.** (B) If the deficiency cannot be completed within 30 days the Plan of Correction must be written in incremental 30 day phases. 1. Within 30 days (12/29/12) the policy will be reviewed andupdated. An Annual review of the policy will occur within the 1Q of every year. 2. Within 30 days (12/29/12) the new Code Orange team members will be identified 3. Code Orange Training will be scheduled within 60 days (1/29/13) and completed within 90 days (2/28/13) 4. Within 30 days (12/29/12) the process for recruitment of Code Orange team members will be completed	

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S0362	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F) (d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following: 6) Ensure that the hospital does the following: (A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.			
	Based on document review and employee interview, the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths.	S0362	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. For the second time in 2012 a	12/29/2012

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	Findings: 1. Review of the contract between the hospital and the Indiana Organ Procurement Organization (IOPO) indicated the hospital shall provide "Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the hospital". 2. Review of the Donation 2012 Statistics and Benchmarks indicated 28 deaths occurred in January 2012 and only 27 deaths were reported. Donation 2012 Statistics and Benchmarks indicated 8 deaths occurred in June 2012 and only 7 deaths were reported. 3. Interview with Employee #A17 November 29, 2012 at 11:30am verified all deaths had not been reported.		missed referral occurred. On 9/12/12 with 29 employees participating, a house-wide nursing colleague education session was provided via Indiana Organ Procurement Organization (IOPO) and Indiana Lions Eye Bank (ILEB) representatives concerning donation referral triggers and the referral process during hospital rounding. An educational focus has been a priority in the high referral areas of the Emergency Department, Critical Care and Cardiovascular Intensive Care Units during September, October and November 2012. Thirty Emergency Department nursing colleagues were educated during mid to late September and October, 2012 utilizing the online IOPO University. Modules completed included referral triggers and the referral process. In addition, the Emergency Department Donate Life Committee representative has provided reinforcement of information about donation referrals on a one-to-one basis. Critical Care and Cardiovascular Intensive Care nursing colleagues were encouraged to complete the IOPO online educational modules on referral throughout the months of September, October and November, 2012 and postings on donation referral triggers and timely referral were posted in the stated units. Education is planned for the	

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			Medical-Telemetry and Medical-Surgical-Pediatrics, Maternal Health, and Behavioral Health units beginning 12/17 and ending 12/29/2012. Educational postings about referral triggers and timely referral, e-mail, a posting in the weekly nursing colleague newsletter "Team Talk" and cards with the links to the IOPO University educational modules on the referral process will be provided. Additional information about the referral process willbe added to the donation information in the nursing orientation packet beginning 12/29/2012. 2. How are you going to prevent the deficiency from reoccurring in the future? Continuing education and reinforcement by the organization Donate Life Committee representatives, visits and educational offerings by the IOPO and ILEB representatives with focused education annually. 3. Who is going to be responsible for 1 and 2 above, include name and title. IU Health La Porte Hospital Donate Life Committee leader Patricia Larson, MSN, CNS, Clinical and Professional Development Coordinator. 4. By what date are you going to have the deficiency corrected?	

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			12/29/2012 (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.** (B) If the deficiency cannot be completed within 30 days the Plan of Correction must be written in incremental 30 day phases.	

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S0554	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on review of policies, manufacturer's instructions, observation, and staff interview, the hospital failed to ensure Cidex, a disinfectant used for high level disinfection of respiratory equipment, was used in accordance with manufacturer's instructions and hospital policy to minimize infection exposure and risk to patients for one of one gallon size bottles of Cidex observed and failed to ensure expiration dates were placed on spray bottles of reconstituted germicidal/disinfectant products for 3 of 11 (The Crossing, Cath Lab, and Playtime Pediatrics Rehab and Laboratory) areas toured. Findings included: 1. Review of polices on 11-27-12 between 9:00 AM and 10:00 AM indicated a policy titled: "Use of Cidex OPA Solution for High Level Disinfection", policy number "RTEQUIP-1a", last revised on "7/28/12" which read: "Record the date the Cidex OPA Solution bottle was opened on the	S0554	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Cath Lab, Playtime Pediatrics (Rehab and Laboratory areas) and The Crossing** By 12/29/2012 environmental service colleagues will be re-educated on the process for labeling reconstituted bottle of chemicals used for environmental cleaning (Virex RTU and Envirox H2Orange2), which will also explain the proper way to legibly label the original bottles with the expiration dates. This will be posted for all environmental service colleagues to read in the form of a departmental memo. Colleagues will be asked to initial the memo as a form of understanding. All bottles will have the expiration date applied by marking the dates on masking tape and then applying masking tape to the bottle. When a bottle of cleaner is opened or reconstituted, the expiration date will be marked on the masking tape and placed on the bottle. If an existing piece of	12/29/2012

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	bottle. Once opened, the remaining solution may be stored in its original container for up to 75 days until used, providing it does not exceed the expiration date on the bottle." 2. Review of manufacturer's instructions located on the side of an opened Cidex OPA Solution bottle on 11-26-12 between 2:30 PM and 2:50 PM read: "Once opened, the unused portion of the solution may be stored in the original container for up to 75 days until used. 3. During tour of the respiratory department on 11-26-12 between 2:30 PM and 2:50 PM, while accompanied by Staff Member #L18, an opened gallon bottle of Cidex OPA Solution was observed in the dirty utility room. Neither the date the bottle was opened nor the expiration date for the opened solution were indicated on the bottle. 4. In interview on 11-26-12 between 2:30 PM and 2:50 PM, Staff Member #L18 acknowledged the above findings.		masking tape is on the bottle, it will be removed and replaced with a newly dated piece of masking tape. The main bottle that is being reconstituted will also be checked at each mixing to make sure the expiration date is readable. If unable to determine the expiration date, the bottle will be discarded. Masking tape will be provided to environmental service colleagues to label bottles legibly. **Respiratory Therapy Area** We threw out the Cidex OPA bottle that was not dated and replaced with a new bottle of Cidex OPA and put the date it was opened (11/27/2012.) Bottle expires 75 days after opening or on expiration date on bottle, whichever comes first. 2. How are you going to prevent the deficiency from reoccurring in the future? **Cath Lab, Playtime Pediatrics (Rehab and Laboratory areas) and The Crossing** Bi-weekly inspections will be completed in Cath Lab, Playtime Pediatrics (Rehab and Laboratory areas) and The Crossing by the 2 nd Shift Team Leader to ensure compliance. A log will be created to keep track of compliance. We will post the above mentioned process in every department where reconstituted chemicals are used.	

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			Respiratory Therapy Area Staff memo was posted in the department for staff to read and sign on 11/29/12. An email was sent to all staff through work and home emails to get the notice out. There is a note posted in the dirty utility room where the Cidex OPA is kept. Staff meeting in January, 2013 will include the proper procedure of Cidex OPA. Once bottle is opened, expiration is 75 days from opening or expiration date on bottle, whichever comes first. All 3 dates will be placed on the bottle: Date Opened, Expiration Dates X 2 plus message to discard on earliest expiration date. 3. Who is going to be responsible for 1 and 2 above, include name and title. **Cath Lab, Playtime Pediatrics (Rehab and Laboratory areas) and The Crossing** Karla Huffman, 2 nd Shift Team Leader will be in charge of inspecting and documenting the cleaning fluids for outdated expiration dates in the Cath Lab, Playtime Pediatrics (Rehab and Laboratory areas) and The Crossing. **Respiratory Therapy Area** Kristy Ewy, CRT Team Leader Respiratory Therapy and Neuro-Sleep Services will complete environmental rounds monthly to check for compliance	

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	150006	A. BUILDING 00 B. WING	11/29/2012

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	5. While on tour of facility and off-site locations (The Crossing and Playtime Pediatrics Rehab and Laboratory) on 11/28/12 at approximately 9:45 AM and 10:30 AM and on 11/29/12 at approximately 12:20 PM, in the company of P31, P44, and P45 the following was observed in: A. The Crossing, lack of expiration date on spray bottles containing Envirox H2Orange2 Concentrate 117 that were reconstituted from a main bottle. The main bottle "use by date" was not readable.		4. By what date are you going to have the deficiency corrected? **Cath Lab, Playtime Pediatrics (Rehab and Laboratory areas) and The Crossing** 12/29/2012 **Respiratory Therapy Area** Deficiency was corrected on the day of violation. 11/27/2012 (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.** (B) If the deficiency cannot be completed within 30 days the Plan of Correction must be written in incremental 30 day phases.	

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	B. Cath Lab, lack of expiration date on spray bottles containing Virex RTU Disinfectant Deodorizing Cleaner that were reconstituted from a main bottle C. Playtime Pediatrics Rehab and Laboratory, lack of expiration date and lot number on the main bottle of Envirox H2Orange2 Concentrate 117 that is reconstituted and put in spray bottles. 6. Personnel P31 was interviewed on 11/29/12 at approximately 10:15 AM and confirmed, spray bottles containing reconstituted H2Orange2 Concentrate 117 were lacking expiration dates and the "use by date" on the main bottle was unreadable. These spray bottles should have an expiration date.			

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S0754	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.			
	Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure properly executed surgical informed consent form for 3 of 4 (N12, N14, and N15) closed patient medical records reviewed for patients who underwent a surgical procedure. Findings: 1. Policy No.: PCD-CONSENT-001 titled, "Informed or Implied Consent, Documentation of" with an effective date of 5/11/09, was reviewed on 11/29/12 at approximately 9:16 AM, and indicated on pg. 3, point 7., "All dates, times and signatures must be in ink, including the signatures of witnesses." 2. Review of closed patient medical	S0754	**S754** ***1. How are you going to correct the deficiency?*** Physicians and Staff members will be educated on the requirement. On 12/19/12 Rhonda Willis, Director of Medical Records, sent a memo to all surgeons on staff at IUH LaPorte educating them on the requirement of signing the surgical consent during the patient's hospitalization. Rhonda will also be asked to be added to the Department of Surgery meeting scheduled for January 8, 2013 to provide one on one education stressing the importance that all surgical consents have the correct signatures, times, and dates following hospital policy PCD-Consent-001. She will also stress that the staff in Surgical Services and Same Day Surgery will be educated by Lisa Pinkstaff and Heather Manley on policy	01/08/2013

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	records on 11/26/12 at approximately 12:46 PM, indicated patient: A. N12: a. per Operative Report Template and Intraoperative Records dated 3/12/12 underwent a left total knee arthroplasty starting at 9:19 AM. b. Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures lacked the date and time of the patient's signature, the witnesses signature, and the physician's signature. Unable to determine if the consent was signed by the patient prior to the start of the surgical procedure. B. N14: a. per Operative Report and Intraoperative Records dated 8/26/12 underwent an open reduction internal fixation of the medial and lateral malleoli together with fixation of the syndesmosis at 18:21 PM. b. Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures lacked the date and time of the physician's signature. Unable to determine if the consent was signed by the patient prior to the start of the surgical procedure. C. N15: a. per Operative Report and Intraoperative Records dated 8/8/12 underwent an abdominal exploration and lysis of severe adhesions from previous		PCD-Consent -001. Lisa Pinkstaff, Director of Surgery, and Heather Manley , Director of Same Day Surgery, will provide education to all surgical staff on 12/19/12 in the way of a read and sign copy of policy PCD-Consent-001 and per organization email that no patient will be taken to surgery without the completion of the surgical and anesthesia consents being complete with correct signatures, times, and dates as per policy PCD-Consent -001. **2. *How are you going to prevent the deficiency from reoccurring?*** Provide education to both physicians and surgery staff as stated above. A random sample closed record review will be completed for surgical patients to ensure surgical consents are signed, dated and timed prior to surgery by the patient and the person witnessing the consent. Lisa Pinkstaff will review 30 charts per month for 1Q 2013. If a 95% or better compliance rate is achieved no further review will be conducted. If it is below 95% it will continue for 2Q 2013 along with individual employee counseling. A closed chart medical record review will be done by the medical records department monthly for three months starting February 1, 2013 to ensure that the surgeon signs the surgical consent	

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	hysterectomy, low anterior colon resection, and stapled anastomosis at 8:21 AM. b. Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures lacked the date and time of the witnesses signature and the physician's signature. Unable to determine if the consent was signed by the patient prior to the start of the surgical procedure. 3. Personnel P42 was interviewed on 11/28/12 at approximately 3:15 PM and confirmed, informed surgical consents need to be signed, dated, and timed prior to the start of the procedure. These were not complete for patients N12, N14, and N15 when reviewed.		sometime during the patient's hospitalization. Any deficiencies will be addressed with the individual physician who is noncompliant and be reported at the Department of Surgery meeting starting 2Q 2013. ***3. Who is responsible?*** Rhonda Willis, RHIA, CCS, CHPS/Director of Medical Records, Privacy Official Lisa Pinkstaff, Director Surgical Services Heather Manley, Director Same Day Surgery ***4. By what date?*** (A) 12/19/12: Physician and Staff Education (B) 1/8/13: Follow up Physician Education	

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S1014	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c) (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. Based on review of policies, manufacturer's instructions, observation, and staff interview, the director of pharmacy failed to ensure written policies for the storage of enteral nutrition products were in accordance with manufacturer's instructions for 4 of 4 enteral nutrition products reviewed and failed to develop and implement written policies and procedures for the appropriate selection, control, and monitoring of high risk/high alert medications for 2 of 11 (Emergency Department {ED}, Same Day Surgery) areas toured. Findings included: 1. Review of policies on 11-27-12 between 2:10 PM and 3:40 PM indicated a policy titled: "HACCP Plan for Enteral Nutrition Products", policy number "FNS-CL-006-1:, last revised on "5/1/2001" which did not indicate enteral	S1014	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Food and Nutrition** The FNS Clinical Policy 006-1 was revised by Mary Morgan to include that all light-sensitive supplement formulas will be stored in the original packaging. Food and Nutrition Staff have been educated and have made the change in which all clear plastic enteral feeding formula containers will be stored in the cardboard shipping package, to prevent exposure to light, and removed only when they are sent to the patient unit for feeding. Education provided on 11/27/12. Education was provided to the staff by Terri Falkenberg in a department meeting. **Pharmacy** Policy RX043 was updated and implemented on 12/12/12 to	12/12/2012

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	nutrition products should be stored away from light. 2. Review of manufacturer's instructions on the bottles of enteral nutrition products on 11-27-12 between 10:00 AM and 12:00 PM indicated: a. "Jevity 1.5 Cal" bottle read: "Contains light-sensitive nutrients." b. "Jevity 1 Cal" bottle read: "Contains light-sensitive nutrients." c. "Glucerna 1.0 Cal" bottle read: "Contains light-sensitive nutrients." d. "TwoCal HN" bottle read: "Protect contents from light during storage." 3. On 11-27-12 between 10:00 AM and 12:00 PM, while on tour of the kitchen while accompanied by Staff Member #L1, the following enteral nutrition products were observed stored on a wire shelf, under light: a. "Jevity 1.5 Cal", 4 bottles b. "Jevity 1 Cal", 11 bottles c. "Glucerna 1.0 Cal", 6 bottles d. "TwoCal HN", 12 bottles 4. In interview on 11-27-12 between 10:00 AM and 12:00 PM, Staff Member #L1 acknowledged the above findings.		include succinylcholine and rocuronium to the high alert medication list. 2. How are you going to prevent the deficiency from reoccurring in the future? **Food and Nutrition** Continue to monitor storage practices to ensure that formula bottles remain enclosed in the cardboard shipping container. New process will be monitored daily by Diana Mebust and / or Terri Falkenberg until practice is adhered to 100% of the time. **Pharmacy** Will add these two medications to the high alert medication list located in policy RX043 and educate staff to what is stated in the policy. 3. Who is going to be responsible for 1 and 2 above, include name and title. **Food and Nutrition** DianaMebust ,Director Food and Nutrition Services; Terri Faulkenburg, Assistant Director Food and Nutrition Services; and Mary Morgan, Clinical Leader. **Pharmacy** Len Slobodskoy, Director of Pharmacy 4. By what date are you going to have the deficiency corrected?	

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	5. While on tour of facility on 11/27/12 at approximately 11:35 AM and 11/28/12 at approximately 3:00 PM, in the company of P30, P31, and P37, the following high risk/high alert medication(s) was(were) observed in the: A. ED Medication Refrigerator, Succinylcholine. B. Same Day Surgery Medication Refrigerator, Succinylcholine and Rocuronium. 6. Policy No.: PCD-RX-043 titled, "High Risk/High Alerts Medications" with an effective date of 11/1/11, was reviewed on 11/29/12 at approximately		**Food and Nutrition** The correction was made on the day of the survey with the change to the policy and practice completed the same day, 11/27/12. **Pharmacy** 12/12/12 (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.** (B) If the deficiency cannot be completed within 30 days the Plan of Correction must be written in incremental 30 day phases.	

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	9:48 AM, and lacked Succinylcholine and Rocuronium on the High-Alert Medication List. 7. Personnel P43 was interviewed on 11/29/12 at approximately 10:00 AM and confirmed all neuromuscular blocking agents should be listed on the High-Alert Medication List in the policy mentioned above. Succinylcholine and Rocuronium are these types of agents, are stored at this facility, and are not listed in this policy.			

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S1022	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. Based on observation, policy and procedure review, and staff interview, the facility failed to ensure appropriate storage conditions for high alert medications according to facility policy and procedure for 2 of 11 (Emergency Department {ED}, Same Day Surgery) areas toured. Findings: 1. While on tour of facility on 11/27/12 at approximately 11:35 AM and 11/28/12 at approximately 3:00 PM, in the company of P30, P31, and P37, the following was observed in the: A. ED Medication Refrigerator, high risk/high alert medications were not labeled as such with tall-man lettering and/or separated appropriately from the general medication inventory. B. Same Day Surgery Medication Refrigerator, high risk/high alert	S1022	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. High Alert Medications have been placed in separate bins and labeled with stickers in the Emergency Room and Same Day Surgery Center, separating them from general medication inventory. This was completed on 12/12/12. High Alert Medication bins are numbered. High Alert Medications have manufacturer's labeling. Tall-Man lettering is utilized on the Pyxis screen and CPOE. 2. How are you going to prevent the deficiency from reoccurring in the future? Pharmacy will inspect High Alert Medication storage areas during monthly environmental inspections. Storage areas to be inspected include pyxis dispensing systems,	12/12/2012

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	medications were not labeled as such with tall-man lettering and/or separated appropriately from the general medication inventory. 2. Policy No.: PCD-RX-043 titled, "High Risk/High Alerts Medications" with an effective date of 11/1/11, was reviewed on 11/29/12 at approximately 9:48 AM, and indicated on pg. 1, under Procedure section, point 2., "All high-risk drugs with a higher potential for dispensing error due to look-alike/sound-alike names will be stored with tall-man labeling..." 3. Personnel P43 was interviewed on 11/29/12 at approximately 10:00 AM and confirmed high risk/high alert medications should be stored separately in cubbies in PYXIS (medication dispensing machine) and were not stored properly at the time of tour.		medication and pyxis refrigerators, anesthesia carts and any other locations housing High Alert Medications. 3. Who is going to be responsible for 1 and 2 above, include name and title. Len Slobodskoy, Pharmacy Director 4. By what date are you going to have the deficiency corrected? 12/12/12 (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.** 12/12/12 (B) If the deficiency cannot be completed within 30 days the Plan of Correction must be written in incremental 30 day phases.	

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S1118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation, review of policies and Material Safety Data Sheets (MSDS), and staff interview, the condition of the physical plant failed to ensure no condition was created or maintained which may result in a hazard to patients or employees in 4 instances. Findings included: 1. During tour of the laboratory on 11-26-12 between 1:45 PM and 2:15 PM while accompanied by Staff Member #L9, the outside of three working bottles containing gram stain solutions were observed in the microbiology department to be covered in stain so that the lot numbers and expiration dates were illegible. The outside of one bottle was covered in a yellow stain so that the label was illegible. In addition, there was no eyewash located in the histology	S1118	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Surgery – Main OR** Deficiency has already been corrected. Sent an email to the OR staff, including the Operating Room Assistants, the day after State Board of Health departed, 11/30/12, reminding them that part of "between case room cleaning" includes cleaning the scrub sink area after each case. Policy, Surgical Services Policy # C-11, has been updated/clarified and sent to OR colleagues for review. The policy will also be reviewed at the AM Board meetings on Friday, 12/14/12 and Monday, 12/17/12, as the revisions will be in effect beginning 12/17/12. **Laboratory – Gram Stain**	12/29/2012

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	department. The histology department was observed to contain the following chemicals: hydrochloric acid (HCl); glacial acetic acid; sodium hydroxide (NaOH); CB Formalin; and CBA Formalin. 2. During tour of "Playtime Pediatrics, Rehab, and Laboratory" on 11-28-12 between 10:15 AM and 11:00 AM while accompanied by Staff Member #L19, a container of "Pretzel Rods" was observed in a closet in the housekeeping room stored on a shelf next to a container of "Lysol" cleaning spray. 3. Review of policies on 11-29-12 between 1:00 PM and 2:00 PM indicated a policy titled: "Use of the Eyewash Station", policy number "LAB-SAF-013", last revised on "11/7/2012", which read: "The eyewash stations should include the following: 1. Be no greater than 10 seconds travel distance from areas in the laboratory where hazardous chemicals or biohazards are present." 4. Review of MSDS on 11-28-12 between 1:15 PM and 1:25 PM indicated the following: a. An MSDS for "Hydrochloric Acid", from "Fisher Scientific", last revised on "31-Oct-2011" which read: "First Aid Measures...Eye Contact...Rinse		This was corrected on 11/26/2012—The bottles were relabeled with labels containing the type of stain, the lot number, and expiration date. These labels are now covered with clear tape to protect the label from stain. **Playtime Pediatrics Rehab and Lab** The environmental service colleagues were educated on 11/30/12 and the pretzel rods were removed from the housekeeping closet at Playtime Pediatrics Rehab and Laboratory. **Histology Eyewash Station** Install a permanent emergency eyewash station within the recommended distance from the Histology Department. The eyewash station will be installed and maintained according to Engineering policy M-700.1. Installation will be done on 12/29/12. 2. How are you going to prevent the deficiency from reoccurring in the future? **Surgery – Main OR** Random spot checks on weekly departmental rounds by Director of Surgery Department. **Laboratory – Gram Stain**	

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	immediately with plenty of water, also under the eyelids, for at least 15 minutes." b. An MSDS for "Acetic Acid", from "Fisher Scientific", last revised on "30-Jul-2010", which read: "First Aid Measures...Eye Contact...Rinse immediately with plenty of water, also under the eyelids, for at least 15 minutes." c. An MSDS for "Sodium hydroxide, solid", author unknown, last revised on "2/15/2008", which read: "First Aid Measures...Eyes: In case of contact, immediately flush eyes with plenty of water for at least 15 minutes." d. An MSDS for "CB Formalin" from "ANATECH LTD.", "Date Prepared: March 2005", which read: "First Aid Measures...Eye: Flush eyes for at least 15 minutes in an eyewash station." e. An MSDS for "CBA Formalin", from "ANATECH LTD.", "Date Prepared: March 2005", which read: "First Aid Measures...Eye: Flush eyes for at least 15 minutes in an eyewash station." 5. In interview on 11-26-12 between 1:45 PM and 2:15 PM, Staff Member #L9 acknowledged the following: a. The working bottles of gram stain solutions located in the microbiology department were covered in stain so that the label on one bottle and the lot numbers and expiration dates on all three bottles were illegible.		Clear tape now covers the labels to protect the label from stain. **Playtime Pediatrics Rehab and Lab** Bi-weekly inspections will be conducted at this location by the assigned team leader of the Environmental Services Department. This assignment will be made by Keri Reinhart. Inspections will begin 12/3/12. **Histology Eyewash Station** Assessing all areas for the need for emergency eyewash / shower will be performed by inclusion to existing Environmental Safety rounds. 3. Who is going to be responsible for 1 and 2 above, include name and title. **Surgery – Main OR** Lisa Pinkstaff, BSN, RN; Director of Surgery **Laboratory – Gram Stain** The Microbiology Section Lead, Jean Knickerbocker, or her designee will be responsible for changing the label with each new lot number and/or if the label becomes illegible. **Playtime Pediatrics Rehab and Lab** Karla Huffman, 2 nd shift Team Leader **Histology Eyewash Station** 1. The installation and testing of	

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	b. The histology department did not have an eyewash station, even though MSDS for 3 of 5 chemicals found in the histology department required eyes to be flushed with water "immediately" upon exposure. 6. In interview on 11-28-12 between 10:15 AM and 11:00 AM, Staff Member #L19 acknowledged "Pretzel Rods" should not be stored in a closet on the same shelf as chemicals, such as "Lysol" spray, in the housekeeping room.		the eyewash station in Histology will be performed by Engineering Services, Ed Aikman- Team Leader. 2. Future evaluations will be performed by the Environment of Care inspection team, verified by the EOC Chairperson- Terry Rhoda. 4. By what date are you going to have the deficiency corrected? **Surgery – Main OR** Already corrected. The Operating Room Assistants got the email message and began cleaning the scrub sinks on 12/3/12. The new policy goes into effect on 12/17/12 and that is when random weekly spot checks will be done. **Laboratory – Gram Stain** 11-26-2012 **Playtime Pediatrics Rehab and Lab** It was corrected on 11/30/12 **Histology Eyewash Station** The installation will be completed by 12/29/2012. (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.** (B) If the deficiency cannot be completed within 30 days the Plan of Correction must be written in incremental 30 day phases.	

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	7. While on tour of facility on 11/27/12 at approximately 2:18 PM, in the company of P31 and P36, it was observed outside the operating rooms in the scrub sink area, green towels (one wet and one dry) hanging over the edge of the sinks. 8. Policy No.: C-11 titled, "Cleaning - Environmental Cleaning in the Perioperative Setting" with an effective date of 12/6/09, was reviewed on 11/27/12 at approximately 4:00 PM, and indicated on pg.: A. 1, under Procedure section, point A.2., "Linen from any open packs, whether soiled or not, are placed in linen hamper bags and sent to laundry for reprocessing. The hamper bags are removed from the stand and replaced with clean ones after each case." B. 3, under Procedure for Operating Suites section, point 14., "Outside the OR (Operating Room) {the scrub area}, scrub the sinks with EPA (Environmental Protection Agency) registered hospital detergent/disinfectant. Take care to dry under the grids in the sink. Spray heads on faucets are to be disassembled and cleaned weekly. Soap dispensers are to be cleaned daily. Wipe under the sinks and all pipes. Wipe the cabinet doors, entrance doors, and push plates or door handles daily. Wet mop the floor using	S1118	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Surgery – Main OR** Deficiency has already been corrected. Sent an email to the OR staff, including the Operating Room Assistants, the day after State Board of Health departed, 11/30/12, reminding them that part of "between case room cleaning" includes cleaning the scrub sink area after each case. Policy, Surgical Services Policy # C-11, has been updated/clarified and sent to OR colleagues for review. The policy will also be reviewed at the AM Board meetings on Friday, 12/14/12 and Monday, 12/17/12, as the revisions will be in effect beginning 12/17/12. **Laboratory – Gram Stain** This was corrected on 11/26/2012—The bottles were relabeled with labels containing the type of stain, the lot number, and expiration date. These labels are now covered with clear tape to protect the label from stain. **Playtime Pediatrics Rehab and Lab** The environmental service colleagues were educated on 11/30/12 and the pretzel rods were removed from the housekeeping closet at Playtime Pediatrics Rehab	12/29/2012

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	wet floor signs as you go."		and Laboratory. **Histology Eyewash Station** Install a permanent emergency eyewash station within the recommended distance from the Histology Department. The eyewash station will be installed and maintained according to Engineering policy M-700.1. Installation will be done on 12/29/12. 2. How are you going to prevent the deficiency from reoccurring in the future? **Surgery – Main OR** Random spot checks on weekly departmental rounds by Director of Surgery Department. **Laboratory – Gram Stain** Clear tape now covers the labels to protect the label from stain. **Playtime Pediatrics Rehab and Lab** Bi-weekly inspections will be conducted at this location by the assigned team leader of the Environmental Services Department. This assignment will be made by Keri Reinhart. Inspections will begin 12/3/12. **Histology Eyewash Station** Assessing all areas for the need for	

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			emergency eyewash / shower will be performed by inclusion to existing Environmental Safety rounds. 3. Who is going to be responsible for 1 and 2 above, include name and title. **Surgery – Main OR** Lisa Pinkstaff, BSN, RN; Director of Surgery **Laboratory – Gram Stain** The Microbiology Section Lead, Jean Knickerbocker, or her designee will be responsible for changing the label with each new lot number and/or if the label becomes illegible. **Playtime Pediatrics Rehab and Lab** Karla Huffman, 2 nd shift Team Leader **Histology Eyewash Station** 1. The installation and testing of the eyewash station in Histology will be performed by Engineering Services, Ed Aikman- Team Leader. 2. Future evaluations will be performed by the Environment of Care inspection team, verified by the EOC Chairperson- Terry Rhoda. 4. By what date are you going to have the deficiency corrected? **Surgery – Main OR** Already corrected. The Operating Room Assistants got the email message and began cleaning the	

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			scrub sinks on 12/3/12. The new policy goes into effect on 12/17/12 and that is when random weekly spot checks will be done. **Laboratory – Gram Stain** 11-26-2012 **Playtime Pediatrics Rehab and Lab** It was corrected on 11/30/12 **Histology Eyewash Station** The installation will be completed by 12/29/2012. (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.** (B) If the deficiency cannot be completed within 30 days the Plan of Correction must be written in incremental 30 day phases.	

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S1172	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (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: (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: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on observation and staff interview, the facility failed to guard against transmission of disease to patients, health care workers, the public, and visitors by failing to maintain clean surfaces around ice machines for 3 of 11 (Same Day Surgery, Outpatient Holding Area, and The Crossing) areas toured and failed to provide appropriate signage on biohazard waste storage area. Findings: 1. While on tour of facility on 11/28/12 at approximately 10:30 AM and 3:00 PM, in the company of P37, P44, and P45, the following was observed in:	S1172	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Staining on countertop, sink, cabinets around ice machine**The countertops are etched from hard water, and need to be replaced in Same day Surgery, Outpatient Holding Area, and The Crossings. Replacement will be of DuPont Corian, or stainless steel. Both of these products are much more durable, and resist staining and etching. New ice machine drain pans will also be installed, and the remaining surrounding areas will be cleaned. Once the new installation has been completed the	01/25/2013

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	A. Same Day Surgery, lack of cleanliness with white spotting/stains around the sink area and on the counter top that the ice machine was sitting on. B. Outpatient Holding Area, lack of cleanliness with white spotting/stains around the sink area and on the counter top that the ice machine was sitting on. C. The Crossing, lack of cleanliness with white spotting/stains around the sink area, the bottom cabinet doors, and the counter top that the ice machine was sitting on. 2. Personnel P31 was interviewed on 11/29/12 at approximately 10:15 AM and confirmed, ice machine areas, including counter tops and cabinet doors, had white spray marks/droplet marks on the surfaces. Staff recognized there was something on the counters, but were not sure what it was.		environmental Services Staff will be educated on how to clean the new surfaces per manufacturer's directions. Education will be provided by Keri Reinhart on 12/29/12 in the Same Day Surgery area, on 01/11/13 in the Outpatient Holding Area, and on 01/25/13 at The Crossings. Education will be provided by documented in-service. **Biohazard Sign**Biohazard sign not posted on door where biohazard waste is kept. Bio hazard sign posted on the door to the biohazard waste area on 11/27/12. 2. How are you going to prevent the deficiency from reoccurring in the future? **Staining on countertop, sink, cabinets around ice machine** Daily cleaning of the new counters will include reporting to the Environmental Services Team Leader, any evidence of future staining and etching. This reporting will be included in the colleague education that will be provided by Keri Reinhart on 12/29/12, 01/11/13, and 01/25/13. **Biohazard Sign**Sign permanently posted. Cannot be removed. 3. Who is going to be responsible for 1 and 2 above, include name and title.	

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			Staining on countertop, sink, cabinets around ice machine V.P. of Hospitality, Don Yurkovich, will obtain the funding for the countertop and pan replacements. The internal construction crew, under the management of Joe Ortt, Facilities Director, will coordinate the replacement. Future cleaning and monitoring of the conditions will be the responsibility of the Environmental Services Department under the management of Keri Reinhart. **Biohazard Sign**Dennis R. Gumbert, PhD, Director, Diagnostic Imaging/Women's Imaging/LifeWorks Imaging 4. By what date are you going to have the deficiency corrected? **Staining on countertop, sink, cabinets around ice machine** The Same Day Surgery area will be completed by 12/29/2012 Outpatient Holding will be completed by 01/11/2013 The Crossing will be replaced by 01/25/2013 **Biohazard Sign**Deficiency corrected 11/27/12 (A) You must provide a specific date that the deficiency **will be or has been corrected. The maximum correction time is 30 days from the date of the survey.**	

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	3. On November 27, 2012 at 2:15pm while on tour of the Lifeworks Imaging offsite area, and in the presence of Employee #A4, it was observed that there was no biohazard sign posted on the door to the biohazard waste storage area.		(B) If the deficiency cannot be completed within 30 days the Plan of Correction must be written in incremental 30 day phases. Education will be provided by Keri Reinhart on 12/29/12 in the Same Day Surgery area, on 01/11/13 in the Outpatient Holding Area, and on 01/25/13 at The Crossings. Education will be provided by documented in-service.	