| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SCHNECK MEDICAL CENTER | 411 W TIPTON ST<br>SEYMOUR, IN 47274 |

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| S 0000<br><br>Bldg. 00 | This visit was for a State licensure survey.<br><br>Facility Number: 005060<br><br>Dates: 2/22/16 to 2/24/16<br><br>QA: cjl 03/17/16<br><br>IDR Committee held on 04-14-16, Tag S1014 modified. JL | S 0000 | | |
| S 0178<br><br>Bldg. 00 | 410 IAC 15-1.3-2<br>POSTING OF LICENSE<br>410 IAC 15-1.3-2(a)<br><br>(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.<br>Based on observation and interview, the hospital failed to conspicuously post their license in an area open to patients and public in each separate hospital building for 3 locations (the main hospital, off-site #1 and off-site #2).<br><br>Findings: | S 0178 | **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** a. The hospital license has been posted in the Cancer Center, Rehab Center and the Patient Lobby. We ensured there is a copy posted in the Patient Lobby. **2. How are you going to prevent the** | 03/23/2016 |

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

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| | 1. Observations as follows:<br>a. On 2/23/16 at 8:30am, during tour of off-site #1, no license was observed posted in a conspicuous location of the facility.<br>b. On 2/23/16 at 8:30am, during tour of off-site #2, in the presence of A16, Regulatory Compliance Officer, it was observed that no license was posted in the lobby or a conspicuous location of the facility.<br>c. On 2/23/16 at 2:10pm, during tour of the main hospital lobby/entrance area with A16 present, no posted license could be located.<br><br>2. On 2/23/16 at 8:30am, A16 indicated being unaware of need to post the hospital license in off-site facilities. At 3:10pm, A16 concluded he/she, also, did not see a license posted in the patient/public/main entrance area of the hospital. | | **deficiency from recurring in the future?** a. Upon receipt of the updated hospital license each of the four locations will be updated. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director , supervisor, etc.** a. The Regulatory Compliance & Disaster Preparedness Coordinator is responsible for compliance. **4. By what date are you going to have the deficiency corrected?**2/22/2016 | |
| S 0406<br><br>Bldg. 00 | 410 IAC 15-1.4-2<br>QUALITY ASSESSMENT AND IMPROVEMENT<br>410 IAC 15-1.4-2(a)(1)<br><br>(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 | | | |

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| | evaluates, but is not limited to, the following:<br><br>(1) All services, including services furnished by a contractor.<br>Based on document review and interview, the Quality Assessment and Performance Improvement (QAPI) program failed to include 6 services (central sterile, inpatient chemotherapy/oncology, infusion therapy, ophthalmic surgery, outpatient psychiatric services, and reconstructive surgery) and 2 off-sites (Off-sites #2 and #3) in the program or its evaluation(s).<br><br>Findings:<br><br>1. Review of the policy titled Continuous Performance & Quality Improvement indicated Each department is responsible for developing a data collection process to monitor important work processes and departmental services. Departmental benchmarks are developed for each data element. The policy was reviewed 3/14.<br><br>2. Review QAPI meeting minutes dated 12/4/15, 7/16/15 and 2/19/15 and 4 quarters of 2015 QAPI departmental reports and dashboards lacked documentation of QAPI review or evaluation of central sterile, inpatient chemotherapy/oncology, infusion therapy, ophthalmic surgery, outpatient | S 0406 | **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** a. These services indicated in the finding will develop indicators and benchmarks that will routinely be reviewed by relevant stakeholders to include the Board of Trustees. **2. How are you going to prevent the deficiency from recurring in the future?** a. The Director of Org. Excellence will include these services in the Quality Audit Checklist process. The Department Directors are responsible for updating the benchmarks and indicators. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director , supervisor, etc.** a. The Director of Org. Excellence and All Department Directors will be responsible for. **4. By what date are you going to have the deficiency corrected?**4/4/2016 | 04/04/2016 |

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| | psychiatric services, and reconstructive surgery or any services of the off-sites #2 and #3.<br><br>3. On 2/24/16 at 3:00pm, S9, Director of Organizational Excellence, indicated the above listed services had not been included in quality review/evaluation for 2015. | | | |
| S 0554<br><br>Bldg. 00 | 410 IAC 15-1.5-2<br>INFECTION CONTROL<br>410 IAC 15-1.5-2(a)<br><br>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.<br>Based on document review, interview and observation, the facility failed to provide a safe and healthful environment in four instances.<br><br>During observation of a surgery patient pre-operative intake and procedure on 02/23/2016 it was noted:<br>1. Policy Cleaning, Handling, Disposal and Storage of Patient Care Equipment and Supplies, (no number) last reviewed 10/2015, indicates:<br>Purpose: To provide guidelines to follow on the use of patient care items.<br>Procedure: Reusable Equipment;<br>C. Non-critical - Most | S 0554 | **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** a. Staff will be re-educated on the correct process, rules and regulations of cleaning stethoscope after each patient use as outlined in the SMC Policy: Cleaning, Handling, Disposal, and Storage of Patient Care Equipment & Supplies. An email was sent to staff outlining the pertinent information in the above mentioned policy. **(Attachment B)** b. There was a new process put in place that required anyone in the OR suite with facial hair is to wear a beard cover. Staff were | 04/06/2016 |

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| | non-critical items may be cleaned where they are used and do not need to be transported to a central processing area. Low-level hospital disinfectants (wipes) or detergents should be used.<br><br>2. Policy Apparel in the Surgical Suite (no number), last updated 11/24/2014, indicated<br>Section 8. Hair is to be covered in the restricted and semi-restricted areas.<br><br>3. At 1130 hours, while observing patient #31 being prepped for a left knee arthroscopy, it was observed that staff member #ANO24, pre-op RN (registered nurse), listened to the patient's lungs with a stethoscope which he/she had worn around his/her neck. After listening to the patient, the nurse immediately put the stethoscope back around his/her neck, without cleaning it.<br><br>4. On 02/23/2016 at 1300 hours, during observation of the same patient #31's surgery, it was observed that staff member #ANO26, orthopedic physician, had a beard which was not fully covered by a surgical mask.<br><br>5. On 02/24/2016 at 1400 hours, staff member # ANO25, Infection Control Nurse, indicated that all staff have been educated that they should wipe off their | | re-educated via an email memo and a picture. **(Attachment A)** c. The therapy balls and hand arch with rings were cleaned and checked per policy on 2/23/2016.A new cleaning log has been created. **(Attachment M)** d. The splint pan will be cleaned by Bio-Med to remove the calcium and rust build up. **2. How are you going to prevent the deficiency from recurring in the future?** a. The infection control process for cleaning of stethoscopes and other patient care items will be audited during Manager and Director rounding. This will be discussed in the Perioperative Services Staff meeting on 4/6/2016. b. The Director of Perioperative Services or designee will audit compliance with appropriate hair coverage on a monthly basis. c. Staff were educated 2/23/2016 on the appropriate process to be followed for cleaning and inspecting the therapy balls and the hand arch with plastic rings. This will be discussed at the 3/30/2016. d. The splint pan PM list will be updated to include cleaning calcium build up and removal of rust. Rehab staff will clean in between PM's. **(Attachment M) 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director , supervisor, etc.** a. The Director of Perioperative Services will be responsible for compliance. b. The Director of Perioperative | |

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| | stethoscopes after patient use and have their hair covered in surgery.<br>6. Review of the policy and procedure P&P titled Infection Control indicated 1. All rehab personnel will follow the established hospital policies. 2. Immediately following contamination, toys or treatment objects will be placed in the designated area to allow for cleaning... The P&P was reviewed 5/15.<br><br>7. Review of the P&P titled Cleaning, Handling, Disposal, and Storage of Patient Care Equipment and Supplies indicated the following: PURPOSE: To prevent the spread of infection... EQUIPMENT: Miscellaneous patient care supplies and equipment. Reusable Patient Equipment: 1. Reusable equipment needs to be cleaned, sanitized, disinfected or sterilized as appropriate. C. Noncritical - These items come in contact with intact skin... The P&P was reviewed 9/15.<br><br>8. On 2/23/16 between 8:30am and 9:30am during tour of the off-site Rehab facility, in the presence of S3, Director of Rehab, the following was observed: In the main therapy room were 4 therapy balls of descending sizes (Large to small), the yellow ball (the smallest) was noted to have blackish debris around the | | Services will be responsible for compliance. c. The Director of Rehab Services will be responsible for compliance. d. The Manager of Bio-Med, Environmental Services & Security will be responsible for compliance. **4. By what date are you going to have the deficiency corrected?** 4/6/2016 | |

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| | ridges on the ball. In room #8, the hand room was an arched plastic tube type device with plastic rings and in the hand therapy room was a splint pan indicated to be off. The interior held approximately 1" of cool water with a white ring around the interior of the basin approximately 1" above the water line. The lid support arm appeared heavily coated with brownish red rust type substance flaking off onto the area below.<br>9. Review of manufacturer recommendations for the splint pan indicated the following: Cleaning: remove solid calcium and mineral build up... Sanitizing the Bath: High heat levels of the baths...effectively sanitize the units, otherwise, the use of isopropyl alcohol for maximum disinfection.<br><br>10. On 2/23/16 at 9:30am, S3 indicated therapy balls were wiped down between patient use, he/she was unaware of the process for cleaning or disinfecting the hand therapy arch with rings, that the therapy balls did not require periodic disinfection, the splint preventive maintenance (PM) was done by the biomedical department, but no intermittent PM was performed in the department and that no documentation was available for cleaning or disinfecting of the above mentioned equipment. | | | |

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| S 1014<br><br>Bldg. 00 | 410 IAC 15-1.5-7<br>PHARMACEUTICAL SERVICES<br>410 IAC 15-1.5-7(c)<br><br>(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.<br>Based on document review, observation and interview, the director of pharmacy failed to ensure implementation of written policies and procedures (P&P) for storage and labeling of medication in 1 instances (1 unlabeled partially filled syringe in a pharmacy refrigerator).<br><br>Findings:<br><br>1. Review of the policy and procedure (P&P) titled Medication Safety & Security indicated the following: PROCEDURE: 1. All medications drawn into a syringe for administration should be labeled with drug name, strength, time, and date. 10. Drugs pulled or sent for one patient should never be used for another patient. 20. Do not recap needles - place in sharps container. The P&P was reviewed 7/14.<br><br>2. On 2/22/16 between 3:00pm and | S 1014 | **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** a. Staff have been re-educated on the SMC policies and procedures for labeling and recapping of syringes. Information is located in the SMC Policy for Medication Safety and Security. b. Patient specific items that have been opened will be disposed of upon discharge of the patient by Pharmacy Staff. c. An IDR was submitted and accepted for the IV Fluid process. **(Attachment D)** d. Staff were re-educated via an email sent to all staff regarding the proper identifiers needed for labeling a syringe. **(Attachment C) 2. How are you going to prevent the deficiency from recurring in the future?** a. Audits will be completed during routine tracers by the Director of Pharmacy & the Regulatory Compliance & Disaster Preparedness Coordinator. b. | 03/24/2016 |

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| | 3:30pm, during tour of the pharmacy, in the presence of A16, Regulatory Compliance Coordinator, and S2, Director of Pharmacy, the following was observed: In a small refrigerator across from the locked drug storage dispenser, was an open box labeled Lorazepam oral concentrate 2 mg/ml, 30ml. Attached to the box was a patient specific label and on the outside of the box was a hand written date 9/19/15 . Inside the box was an unopened vial labeled Lorazepam, and a syringe (capped needle attached) with approximately 0.5ml clear fluid. The syringe lacked a label or documentation of drug name, strength, time and date.<br><br>3. On 2/22/16 between 3:00pm and 3:30pm, S2 indicated the fluid filled syringe in the refrigerator was likely for a patient that had been discharged, the syringe should have been labeled, the needle not recapped and discarded after use, and the entire syringe and contents discarded before now. | | Periodic audits of items stored in the Pharmacy refrigerators will be conducted by Techs and the Regulatory Compliance & Disaster Preparedness Coordinator looking for unlabeled syringes and used patient items that need disposed of. c. SMC will continue to look at the IV fluid process periodically for re-evaluation. d. Staff will be educated during NEO and during routine tracers completed by the Regulatory Compliance & Disaster Preparedness Coordinator. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director , supervisor, etc.** a. - d. The Director of Pharmacy and the Regulatory Compliance Coordinator will be responsible for compliance. **4. By what date are you going to have the deficiency corrected?** 3/24/2016 | |
| S 1024<br><br>Bldg. 00 | 410 IAC 15-1.5-7<br>PHARMACEUTICAL SERVICES<br>410 IAC 15-1.5-7 (d)(2)(C)<br><br>(d) Written policies and procedures shall be developed and implemented that include the following: | | | |

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| | (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:<br><br>(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.<br>Based on document review, observation and interview, the director of pharmacy failed to ensure monthly inspections detected and quarantined outdated or otherwise unusable drugs and biologicals for 7 medications (1 unlabeled syringe, 1 vial Lidocaine 1%, 1 vial Xylocaine 1%, and 4 pre-filled 0.9% sodium chloride syringes).<br><br>Findings:<br><br>1. Review of the policy and procedure (P&P) titled Medication Vials Use and Expiration indicated the following: PROCEDURE: 4. Once a multiple dose vial has been opened, it should: a. Be labeled with the expiration date, which is 28 days from the date opened... The P&P was last reviewed 9/14.<br><br>2. Review of the policy and procedure (P&P) titled Infection Control/Safety Guidelines indicated Discontinued or outdated drugs...will be returned to the | S 1024 | **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** a. The Lorazepam was disposed of while the Surveyor was on-site. b. The vial was removed from the drawer in which it was found while the Surveyor was on-site. c. The syringes were disposed of while the surveyor was on-site. **2. How are you going to prevent the deficiency from recurring in the future?** a. Staff have been re-educated on the SMC Policy for Medication Safety and Security Policy & the SMC Policy for Medication Vials Use and Expiration. b. Cabinets/drawers containing medication will be checked on a monthly basis by the Cardiovascular nurses and documented on a log. c. A the Wound Care nurses will check on a quarterly basis for expired meds and log any deficiency on a newly created log sheet. **(Attachment E) 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director ,** | 03/23/2016 |

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| | pharmacy for proper disposition. The P&P was last reviewed 6/14.<br><br>3. The following was observed on the dates and times as indicated:<br>a. On 2/22/16 at 3:10pm, during tour of the hospital pharmacy, in the presence of A16, Regulatory Compliance Coordinator, and S2, Director of Pharmacy, in a small refrigerator across from the locked drug storage dispenser, was an open box labeled Lorazepam oral concentrate 2 mg/ml, 30ml. The outside of the box in writing was a hand written date 9/19/15 . Inside the box was an unopened vial labeled Lorazepam, and a needle capped syringe with approximately 0.5ml clear fluid. The syringe lacked a label or documentation of drug name, strength, time and date.<br>b. On 2/22/16 at 4:00pm, in the presence of A16 and S1, Director of Cardiovascular and Nutrition, in the hospital Cardiac Rehabilitation (Rehab) area Echocardiogram room, inside a box in a locked drawer was an opened, partially filled vial of Lidocaine 1% with a written date of 9/21/15 and 2 initials.<br>c. On 2/23/16 at 9:25am, during tour of the off-site Rehabilitation facility, in the presence of A16 and S3, Director of Rehab, inside a supply/treatment cabinet was the following: 1 opened, partially used vial of Xylocaine 1% without an | | **supervisor, etc.** a. The Director of Pharmacy is responsible for compliance. b. The Director of Cardiovascular Services is responsible for compliance. c. The Director of Rehab Services is responsible for compliance. **4. By what date are you going to have the deficiency corrected?** 2/22/2016 | |

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| | opened or 28 day expiration date and 4 packaged pre-filled 0.9% sodium chloride syringes with manufacturer stamp Exp. Aug. 2014 (Expiration: August 214)<br><br>4. On 2/22/16 at 3:10pm, S2 indicated the partially fluid filled syringe in the refrigerator should have been labeled with medication identification and expiration date and discarded before now.<br><br>5. On 2/22/16 at 4:00pm, S1 indicated the Lidocaine in the drawer was outdated/expired and should have been discarded.<br><br>6. On 2/23/16 at 9:25am, S3 indicated verified the Xylocaine and pre-filled sodium chloride syringes were outdated/expired and should have been discarded. | | | |
| S 1118<br><br>Bldg. 00 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8 (b)(2)<br><br>(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 | | | |

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| | 150065 | A. BUILDING 00<br>B. WING | 02/24/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| | assured as follows:<br><br>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.<br>Based on observation and interview, the facility failed to ensure patient safety in two instances, risking patient burns.<br><br>Findings:<br><br>1. While touring the Intensive Care Unit on 02/22/2016 at 1210 hours, accompanied by staff member ANO27, it was noted that the blanket warmer thermometer registered 150 degrees Fahrenheit (F). The blanket temperature dial was set on 130 degrees F. A blanket warmer temperature log header indicated the temperature should not be over 130 degrees F.<br><br>2. Staff member ANO27 indicated that it was too warm, even though it had preventive maintenance recently, and would have the maintenance department check it.<br><br>3. While touring the Pediatric Unit on 02/24/2016 at 1200 hours, with staff member # ANO28, it was observed that the blanket warmer lacked a temperature log. | S 1118 | **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** a. The blanket warmer temperature dial was set to the correct temperature of 130 degrees. **2. How are you going to prevent the deficiency from recurring in the future?** a. Staff were re-educated on the best practice setting of 130 degrees. A Blanket Warmer Log has been created to be used for all Blanket Warmers. **(Attachment O) 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director , supervisor, etc.** a. The Director of each unit that houses a blanket warmer and the Regulatory Compliance & Disaster Preparedness Coordinator will be responsible to periodically check the temperature log to ensure it is 130 degrees or below. **4. By what date are you going to have the deficiency corrected?** 3/24/2016 | 03/24/2016 |

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| | 4. Staff member #ANO28 indicated that there should be a blanket warmer temperature log being used. | | | |
| S 1164<br><br>Bldg. 00 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8(d)(2)(B)<br><br>(d) The equipment requirements are as follows:<br>(2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:<br><br>(B) There shall be evidence of preventive maintenance on all equipment.<br>Based on observation, document review and interview, the hospital failed to provide evidence of preventative maintenance (PM) for 7 equipment items [patient walkers, CT (computed topography) scanner, dietary dishwasher, gamma camera, mammography scanner, renal dialysis machine, and boiler room shower wash].<br><br>Findings:<br><br>1. Review of the policy titled Medical Equipment Management Plan indicated the following: C. 1. The risk assessment function...allows departments to analyze | S 1164 | **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** a. The tips of the walker in question have been replaced. b. The shower in the boiler room has been cleaned and a PM log has been created. The PM log will be used for all Decontamination showers in the hospital. **(Attachment K)** c. The PM's listed as deficient are completed on a routine schedule. The PM's are tracked in MediMizer which is a hospital management software used by our Bio-Medical Engineering Department.<br>**2. How are you going to** | 04/25/2016 |

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| | and assess equipment devices in PM frequencies and tasks. D. The frequency and task intensity...is determined by the equipment's Risk Score. NOTE: The equipment inventory is continuously updated throughout the year, along with an annual inventory. I. The hospital documents performance and safety testing of all equipment identified in the medical equipment management program. The policy was reviewed and revised 11/14.<br><br>2. Review of manufacturer guidelines provided by S3 for the walkers, indicated the following: Before each use make sure...Tips are in good condition. Replace tips immediately when worn or missing.<br><br>3. On 2/23/16 between 8:30am and 9:30am during tour of the offsite Rehabilitation (Rehab) facility, in the presence of A16, Regulatory Compliance Coordinator, and S3, Director of Rehab, the following was observed: hanging on a wall in the main therapy room were 3 patient walkers, one noted with a worn leg tip and tape dangling from the tip.<br><br>4. On 2/23/16 at 3:50pm, in the presence of S6, Director of Facilities, in the boiler room of the main hospital was an eyewash and shower station. The shower | | **prevent the deficiency from recurring in the future?** a. The walkers will be checked per the new guidelines outlined in the Medical Equipment Management Plan and the Rehab Gait Training Policy. b. The Eyewash & Decontamination Shower Policy has been updated to include a log for the decon shower. Staff will be educated on 4/25/16. c. The PM's for the items shown on a routine PM schedule that is tracked in MediMizer. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director , supervisor, etc.** a. The Director of Rehab Services will be responsible for compliance. b. The Director of each unit with a decontamination shower and the Regulatory Compliance & Disaster Preparedness Coordinator will be responsible for maintaining compliance. c. The Manager of Bio-Med, Environmental Services & Security will be responsible for compliance. **4. By what date are you going to have the deficiency corrected?** 4/25/2016 | |

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| | head spray area was observed to be dripping clear fluid and very heavily coated with a white powdery appearing substance. Hanging beside the eyewash basin was a clipboard with a paper titled Eyewash Station Operation Checklist. The checklist lacked documentation of PM for the shower wash or spray head.<br><br>5. On 2/23/16 at 9:30am, S3 indicated department staff did not maintain documentation of regular checks or other periodic PM for any walker.<br><br>6. Review of 2015 through January 2016 PM documentation with A16, lacked documentation of PM for any walker, CT scanner, dietary dishwasher, gamma camera, mammography scanner, renal dialysis machine or the boiler room shower wash).<br><br>7. On 2/23/16 at 2:30pm, S6 indicated the hospital did not have a PM waiver from the State for equipment management.<br><br>8. On 2/24/16 at 10:00am, A16 indicated documentation of PM for a CT scanner, dietary dishwasher, gamma camera, mammography scanner, renal dialysis machine and boiler room shower wash were not available. On 2/25/16, via email at 3:40pm, A16 indicated the | | | |

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| | hospital did not have a Risk Score for the equipment without PM documentation. | | | |
| S 1172<br>Bldg. 00 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8(e)(1)(A)(B)(C)<br><br>(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:<br><br>(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:<br><br>(A) Asepsis<br>(B) Cross-infection; and<br>(C) Safe practice.<br>Based on observation, the hospital failed to maintain a clean and orderly environment in 5 areas (The Off-site Rehabilitation facility, hospital diagnostic imaging patient care, radiology staff lounge, bulk supply/central storage and plant operations break room). | S 1172 | **1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** a. The items cited in this deficiency were cleaned on 2/23/2016. A new cleaning log has been created. **(Attachment M)** b. & c. The items cited in this | 03/23/2016 |

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| | Findings:<br><br>1. The following was observed in areas and on dates as indicated:<br>a. On 2/23/16 between 8:30am and 9:30am during tour of the off-site Rehabilitation (Rehab) facility, in the presence of A16, Regulatory Compliance Coordinator, and S3, Director of Rehab, in the physical therapy room, dust was observed on the traction machine; in the main therapy area heavy dust was noted atop the hand towel dispenser and atop the soap dispenser; and in room #9, the pediatric therapy room, heavy dust was observed on the ledge of the drop down table.<br>b. On 2/23/16 at 2:35pm during hospital tour, in the presence S7, Manager of Diagnostic Imaging in the diagnostic imaging area, heavy black dust was noted on top of the X-ray generator/GenRad 1 box and dust was observed on the fluid warmer in room CT2.<br>c. On 2/23/16 at 2:55pm, in the presence of S7, in the radiology staff lounge heavy dust was noted on top of lockers, the inside of the microwave was observed to have dried food type particles, and the coffee maker was coated with a dust type substance.<br>d. On 2/23/16 at 3:30pm during hospital | | deficiency were cleaned on 2/23/2016. d. The storeroom was swept and the floor was cleaned to remove the rust colored dust on 2/23/2016. e. The Plant Operations Department break room and refrigerator were cleaned on 2/23/2016. - Staff have weekly, monthly or quarterly cleaning logs to follow for specific items. In addition Environmental Services has cleaning descriptions for each area. **2. How are you going to prevent the deficiency from recurring in the future?** a The Environmental Services Staff cleaning description has been updated to include the items in this finding. **(Attachment L)** b. & c. The Diagnostic Imaging staff will be responsible for cleaning all DI equipment. A new log has been created to track compliance. **(Attachment N)** d. The storeroom will be swept and mopped on a routine basis. A work order request to Environmental Services will be entered to have the floor cleaned with the floor cleaning machine on a PRN basis. e. The Plant Operations break room and refrigerator will be cleaned on a weekly basis. **3. Who is going to be responsible for numbers 1 and 2 above; i.e., director , supervisor, etc.** a. The Director of Rehab Services is responsible for compliance. b. & c. The Director of Diagnostic Imaging is responsible for compliance. d. | |

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| | tour, in the presence of S6, Director of Facilities, in the bulk supply area, tanish/brown mixed debris and dust was noted under a large table in the bulk room and heavy dark colored dust, rubber bands and other debris was noted in and on a stack of bariatric bedpans which stored on a shelf among other hospital supplies in the general storage area.<br>e. On 2/23/16 at 3:45pm, in the presence of S6, in the Plant Operations break room, inside the staff refrigerator were food items, a thick brownish, dried appearing, substance was observed on one of the plastic shelves and heavy black dust type debris on the shelves of the interior door. | | The Director of Materials Management and the Regulatory Compliance & Disaster Preparedness Coordinator are responsible for compliance. e. The Director of Facilities is responsible for compliance. **4. By what date are you going to have the deficiency corrected?** 2/23/2016 | |