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ST JOSEPH HOSPITAL	700 BROADWAY FORT WAYNE, IN 46802

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S 0000 Bldg. 00	The visit was for a State licensure survey. Facility Number: 005043 Survey Date: 2/20-22/17 QA 4/18/17 LH	S 0000		
S 0270 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up. Based on document review and interview, the governing board failed to perform a quarterly review of quality monitoring reports including patient services provided at the facility for 4 of 4 quarters in 2016. Findings include:	S 0270	1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **During survey, the 2016 Organization-ide Quality Assessment and Performance Improvement Program was provided. The Program outlines**	02/22/2017

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

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	1. Review of the 2016 Quality Improvement Program (approved 5-16) indicated the following: "The Board shall facilitate Quality Improvement by: ...Reviewing, accepting or rejecting periodic reports on findings, actions, and results of program activities... Directors and Managers of those departments and services that impact patient care are responsible for the systematic monitoring and analysis of the quality and safety of care provided in their departments ... [and]... Evaluate the performance of all clinically contracted services..." 2. Review of governing board meeting documentation dated 2-11-16, 3-31-16, 5-19-16, 7-27-16, 9-15-16, 11-17-16 and 1-19-17 lacked documentation indicating any department or service PI (Preformance Improvement) dashboards were presented or reviewed by the board. 3. On 2-21-17 at 1140 hours, the Director of Quality, staff A3 confirmed the 2016 board meeting minutes failed to indicate any PI dashboards or department/service reports were reviewed.		**that the Quality Council is the multidisciplinary body that serves to oversee, coordinate, direct, and collaborate on organizational quality improvement activities. Membership includes Medical Staff, Senior Leadership (CEO, CNO, CQO, Patient Safety Officer, and other clinical and non-clinical staff as appropriate such as Pharmacy Director. Quality monitoring reports were reviewed during the January, February, March, April, May , June, July, August, September, October, and December meetings. Quality was also reviewed and accepted during Medical Executive Committee meetings. The 2016 Quality program indicates that the Governing Board authorizes the establishment of the Quality Council to implement the Quality Improvement program and periodic reports will be reviewed, accepted or rejected. 2016 Board minutes reflect the review and acceptance Quality Council/MEC minutes which include quality improvement activities. The 2016 Board minutes reflect summary reports of quality data during February, March, May, July, September and November. Summary reports represents various departments/service.** 1.How are you going to prevent the deficiency from recurring in the future?	

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			Chief Quality Officer to continue to assist with Quality Council, Medical Executive Committee, and Board Agenda to ensure quality improvement activities including quality monitoring reports are reviewed as directed by hospital's Quality Program. The executive dashboard will be reviewed for recommendations, acceptance, periodically as outlined in the Quality Program. Review of Governing board meeting minutes to ensure compliance. 1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Chief Quality Officer is ultimately responsible for the deficiency and overall and ongoing compliance.** 1.By what date are you going to have the deficiency corrected? **February 22, 2017**	
S 0332 Bldg. 00	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:			

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	(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures. Based on document review and interview, the governing board failed to perform a quarterly review of quality monitoring reports including patient services provided at the facility for 4 of 4 quarters in 2016. Findings include: 1. Review of the 2016 Quality Improvement Program (approved 5-16) indicated the following: "The Board shall facilitate Quality Improvement by: ...Reviewing, accepting or rejecting periodic reports on findings, actions, and results of program activities... Directors and Managers of those departments and services that impact patient care are responsible for the systematic monitoring and analysis of the quality and safety of care provided in their departments ... [and]... Evaluate the performance of all clinically contracted services..." 2. Review of governing board meeting documentation dated 2-11-16, 3-31-16, 5-19-16, 7-27-16, 9-15-16, 11-17-16 and 1-19-17 lacked documentation indicating any department or service PI	S 0332	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **During survey, the 2016 Organization-ide Quality Assessment and Performance Improvement Program was provided. The Program outlines that the Quality Council is the multidisciplinary body that serves to oversee, coordinate, direct, and collaborate on organizational quality improvement activities. Membership includes Medical Staff, Senior Leadership (CEO, CNO, CQO, Patient Safety Officer, and other clinical and non-clinical staff as appropriate such as Pharmacy Director. Quality monitoring reports were reviewed during the January, February, March, April, May , June, July, August, September, October, and December meetings. Quality was also reviewed and accepted during Medical Executive Committee meetings. The 2016 Quality program indicates that the Governing Board authorizes the establishment of the Quality Council to implement the Quality Improvement program and periodic**	02/22/2017

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	(Preformance Improvement) dashboards were presented or reviewed by the board. 3. On 2-21-17 at 1140 hours, the Director of Quality, staff A3 confirmed the 2016 board meeting minutes failed to indicate any PI dashboards or department/service reports were reviewed.		**reports will be reviewed, accepted or rejected. 2016 Board minutes reflect the review and acceptance Quality Council/MEC minutes which include quality improvement activities. The 2016 Board minutes reflect summary reports of quality data during February, March, May, July, September and November. Summary reports represents various departments/service.** 2. How are you going to prevent the deficiency from recurring in the future? **Chief Quality Officer to continue to assist with Quality Council, Medical Executive Committee, and Board Agendas to ensure quality improvement activities including quality monitoring reports are reviewed as directed by hospital's Quality Program. The executive dashboard will be reviewed for recommendations, acceptance, periodically as outlined in the Quality Program. Review of Governing board meeting minutes to ensure compliance.** 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Chief Quality Officer is ultimately responsible for the deficiency and overall and ongoing compliance.**	

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			4. By what date are you going to have the deficiency corrected? **February 22, 2017**	
S 0408 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D) (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: (2) All functions, including but not limited to the following: (A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).			
	Based on document review and interview, the facility failed to assure all services were evaluated and reviewed through the Quality Assessment and Performance Improvement (QAPI) program for 1 service (discharge planning). Findings include:	S 0408	How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **During survey, the 2016 Organization-ide Quality Assessment and Performance Improvement Program was provided. The Program outlines**	02/22/2017

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	1. Review of the 2016 Quality Improvement Program (approved 5-16) indicated the following: "Directors and Managers of those departments and services that impact patient care are responsible for the systematic monitoring and analysis of the quality and safety of care provided in their departments ..." 2. Review of 2016 department and service performance improvement (PI) dashboards failed to indicate reporting on the discharge planning services at the facility. 3. On 2-22-17 at 1030 hours, the Director of Clinical Services, staff A8 confirmed no report or PI dashboard for the discharge planning services at the facility was available.		**that the Quality Council is the multidisciplinary body that serves to oversee, coordinate, direct, and collaborate on organizational quality improvement activities. Membership includes Medical Staff, Senior Leadership (CEO, CNO, CQO, Patient Safety Officer, and other clinical and non-clinical staff as appropriate such as Pharmacy Director. Performance Improvement reports were reviewed during the January, February, March, April, May , June, July, August, September, October, and December meetings. Quality monitoring was also reviewed and accepted during Medical Executive Committee meetings. The 2016 Quality program indicates that the Governing Board authorizes the establishment of the Quality Council to implement the Quality Improvement program and periodic reports will be reviewed, accepted or rejected. 2016 Board minutes reflect the review and acceptance Quality Council/MEC minutes which include quality improvement activities. The Medical Staff Bylaws approved by the Governing Board on November 2016 was requested and reviewed during survey. Utilization Committee, chaired by appointed Chief given authority by MEC and Board of Trustee to monitor and evaluate Utilization quality services. The Utilization Review Committee met quarterly in 2016 and discharge planning**	

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			services quality monitoring reports were reviewed and accepted. Utilization Management Committee full detailed reports were included in the Quality Council and MEC meetings, not dashboards. Utilization report was accepted during the Governing Board meetings with Quality Council/MEC minutes. 2. How are you going to prevent the deficiency from recurring in the future? **Chief Quality Officer will continue to assist with Quality Council, Medical Executive Committee, and Board Agendas to ensure quality improvement activities including quality monitoring reports are reviewed as directed by hospital's Quality Program. The executive dashboard, which includes utilization monitoring will be reviewed for recommendations, acceptance, periodically as outlined in the Quality Program. Review of Governing board meeting minutes to ensure compliance.** 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Chief Quality Officer is ultimately responsible for the deficiency and overall and ongoing compliance.**	

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			4. By what date are you going to have the deficiency corrected? **February 22, 2017**	
S 0554 Bldg. 00	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 observation and interview the facility failed to maintain the facility, in regard to repair of the physical plant in the burn unit. Findings Include: 1. While on tour of the burn unit at 11:10 AM on 2/20/17, in the company of staff member #54, the CNO (Chief Nursing Officer), it was observed that a 3 foot long section of wall (4 to 5 inches high) above the baseboard in patient room #4 was banged up/chipped and with deep indentations that could not be disinfected appropriately. 2. Staff member #54 confirmed the damage of the wall in room #4 at 11:10 AM on 2/20/17. 3. At 11:40 AM on 2/20/17, interview	S 0554	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **During survey, work order was placed to address the damaged wall in the Burn Center and the repairs were completed by March 1, 2017. All burn center staff were re-educated to review rooms for damage daily, and if and when integrity within the environment is compromised to place a work order.** **Re-educated of the work order entry was reviewed by Nurse Manager during February and March. All burn unit clinical staff who were re-educated and expectations were emphasized on placing work order if and when environmental damages including chipped walls**	03/01/2017

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	with the housekeeping manager, staff member #63, confirmed that housekeeping staff cannot sufficiently disinfect the wall of patient room #4 in the burn unit with the disruption of the surface as it occurs presently. 4. At 12:30 PM on 2/20/17, interview with the Director of Support Services, staff member #56 confirmed that staff must complete a work order when areas, such as the wall of room #4 in the burn unit, need repair.		2. How are you going to prevent the deficiency from recurring in the future? **The requirement to enter work order is reviewed during unit orientation. All burn unit clinical staff are educated and expectations were emphasized on placing work order if and when environmental damages including chipped walls are identified during safety huddles, unit meetings, and one on one education during the month of February and March.** **The room will be taken out of service until the repairs can be fixed.** **Once the repairs have been made, housekeeping will then be notified to perform their cleaning process so the room can be placed back in service.** **Burn Nurse Manager will perform monthly environment of care audits for four consecutive months to ensure compliance with environment integrity and cleanliness. The data will be presented at Patient Safety and up to the Quality Council and Medical Executive Committee.**	

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			3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Nurse Manager is ultimately responsible for the deficiency and overall and ongoing compliance.** 4. By what date are you going to have the deficiency corrected? **March 1, 2017**	
S 0556 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers. Based on document review, interview and observation, the facility failed to ensure an active and effective infection control program related to the lack of an annual TB (tuberculosis) risk assessment and related to the lack of oversight of the contracted cleaning companies and their cleaning products used at three off site locations.	S 0556	How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Infection Prevention Nurse was re-educated on completion of annual risk assessment.** **2016 TB Risk assessment was completed in March 2017 and**	04/14/2017

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	Findings Include: 1. Review of the 2016 Infection Control Plan/Program indicated under "Ongoing Surveillance", on page 4, that "Annual TB risk assessment" was part of this; and under Surveillance Activities, pages 8 & 9: "Viii. Monitor: PPD (purified protein derivative) skin test conversions in hospital employees. Rationale: Tuberculosis is a significant public health problem. This organization serves patients who are immunocompromised, underserved in health care, homeless, and jail inmates. Employees are at a higher risk for TB exposure due to the patient population served. Methodology: All employees will be screened for TB on a yearly basis or more often...Data source: Employee physical reports,...and annual TB risk assessment (Low Risk)...". 2. Review of the TB Control Plan, policy number IC 160, last approved 2/2016, indicated on page 4 under 26., "TB Risk Assessment i. Based on the risk assessment, the TB infection control plan will be evaluated yearly...". 3. Review of the most recent TB Risk Assessment Worksheet indicated a completion date of 9/10/2015.		**approved by the Infection Control Committee on April 14, 2017.** **All identified staff members were re-educated on adhering to annual TB testing requirements and TB testing was obtained during March and April.** **New Employee health team aware of TB Risk Assessment and monitor compliance outlined in TB Risk Assessment on an annual basis.** **Off site location unapproved cleaning products were removed from service on February 22, 2017 and hospital based Infection Control Committee approved products/EPA registered were used to clean rooms. Contract cleaning staff were educated on appropriate products by the Infection Control Nurse during the month of February.** **Chief Quality Officer re-educated Infection Control Nurse on the IC committee responsibility to review and approve offsite cleaning products to ensure EPA registry.** 2. How are you going to prevent the deficiency from recurring in the future? **Infection Control Prevention was re-educated on completion of**	

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	4. Review of personnel files indicated: A. Staff member N7 was hired 5/19/14 and had only a new employee TB test documented in 2014. B. Staff member N9 was hired 1/25/15 and had only the new employee TB test of 2015 in their file. C. Staff member N10 was hired on 11/2/15 and had a Quantiferon Gold test done in 2015. 5. At 12:10 PM on 2/22/17, interview with the IC (infection control) nurse, staff member #58, confirmed that: A. It could not be found in any meeting minutes of the IC committee that the 9/2015 TB risk assessment was accepted/approved. B. There was no docuentation that the committee had decided the facility was low risk and that annual TB testing would be eliminated, except for certain departments. C. Staff, as listed in 4 above, lacked annual TB test results as it was assumed the IC committee had approved no longer completing annual TB tests. D. There was no 2016 annual TB risk assessment completed, as policies indicated would be done. 6. At 9:30 AM on 2/21/17, while on tour of the off site Lake Avenue imaging location in the company of the COO		**annual TB Risk assessment and approval of the infection control committee. Required annual plans have been placed on the mandatory review schedule and will be monitored by the Chief Quality Officer quarterly.** **New hires are educated on TB testing requirements during orientation and annually. New Employee Health team will monitor annual compliance outline in the TB Risk Assessment and if and when noncompliance will be reported to department managers and human resources. TB testing compliance will be presented at Infection Control Meeting and up to the Quality Council and Medical Executive Committee.** **Contract cleaning staff will be educated to clean with hospital approved products during orientation and if and when hospital based Infection Control Committee approved products are changed. Monthly audits will be submitted by the contract cleaning service for four consecutive months. Onsite product utilization audit will be conducted annually by the Infection Control Nurse. Product compliance will be presented at the Infection Control Committee, Patient Safety, and up to the Quality Council and Medical Executive Committee.**	

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	(chief operating officer), staff member #51, it was observed in a housekeeping closet that Fabuloso, Windex, and Ajax Glass and Multi surface cleaner was being used to clean/disinfect the facility by the contracted housekeeping company. Rag head mop heads were also observed in the housekeeping closet. 7. At 10:15 AM on 2/21/17, interview with staff member #58, the IC director, confirmed that: A. This staff member, and the IC committee, have had no oversight of the cleaning processes utilized by the two contracted companies at the three off site locations. B. Fabuloso, and the other products found in the housekeeping closet, were not EPA (environmental protection agency) registered, nor hospital grade, and were not disinfectants, so they should not be used at the off site location(s). C. The cleaning products used by the two contracted housekeeping companies have not been approved by the IC committee. D. It was unknown how/where rag head mop heads were laundered by the contracted housekeeping companies to ensure proper disinfection occurs. `		3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Human Resource Director along with the Infection Control Nurse is ultimately responsible for the deficiency and overall and ongoing compliance for TB Risk Assessment and Testing.** **Infection Control Nurse is ultimately responsible for the deficiency and overall and ongoing compliance for offsite cleaning products** 4. By what date are you going to have the deficiency corrected? **April 14, 2017**	

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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
S 0598 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv) (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: (iv) Aseptic technique, invasive procedures, and equipment usage. Based on document review, observation and interview, the facility failed to follow its instrument processing policy for 1 of 1 Burn Unit. Findings Include: 1. Review of policy 6-400 approved 02/1016, stated under "II. Procedure, A. Cleaning instruments prior to transport, 3. Place in appropriate container (puncture proof, sealed lid, labeled as biohazard)". 2. During tour of the Burn Unit on 02/20/17 in the company of A 4 - Quality Coordinator and A 5, Chief Nursing the hydrotherapy room.	S 0598	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **During survey, all instruments in the hydrotherapy sink were placed in an appropriate container which was puncture resistant, had a lid and the biohazard sticker affixed… appropriate solution was utilized, and the instruments were transported for processing per policy.** **The requirement of instrument placement, cleaning, and transporting is located in the Cleaning instruments prior to transport policy. All burn unit clinical staff who perform instrument processing were**	04/01/2017

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	3. Interview with A5 -Chief Nursing Officer and A-4 - Quality Coordinator on 02/20/17 at 11:20 am, confirmed that the instruments should be in a hard container as per policy requirements.		**re-educated on policy 6-400 Procedure, Cleaning instruments prior to transport by Burn Nurse Manager during safety huddles, unit meetings, and one on one education during the month of February and March.** 1. How are you going to prevent the deficiency from recurring in the future? **Burn center staff are educated on Cleaning instruments prior to transport during orientation, annually, and if and when policy changes.** **Burn Nurse Manager will perform ten monthly audits for four consecutive months to ensure compliance with Cleaning instruments prior to transport. The data will be presented at Infection Control Committee, Patient Safety and up to the Quality Council and Medical Executive Committee.** 2. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Nurse Manager is ultimately responsible for the deficiency and overall and ongoing compliance.** 3. By what date are you going to have the deficiency corrected?	

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			April 1, 2017	
S 0606 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review and interview, the infection control committee and employee health staff failed to implement the policy related to the immune status of communicable diseases for 2 of 5 RNs (registered nurses), staff members N10 and N13, and failed to implement policy related to Hepatitis B status for 1 of 1 dialysis nurses, staff member N13. Findings Include: 1. Review of the policy Pre-Employment	S 0606	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **The Pre-Employment Health Screening policy HS 120 related to immunity status communicable diseases, including hepatitis was implemented in 2012. The immunity status for the identified clinical staff was communicated. Staff informed of immunization booster and immunity status check requirements. Missing immunity information was provided and file updated.**	04/01/2017

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	Health Screening, policy number HS 120, last approved 9/2012, indicated under Procedure, in section 3.: "Immunity/Immunization Status...B. Healthcare personnel will be offered vaccination in conjunction with CDC (Centers for Disease Control) guidelines as indicated in the following table. Varicella, Measles, Mumps and Rubella immunity are indicated for new employees...C. Hepatitis B declination must be signed if the employee is declining the Hepatitis B vaccine for any reason...". 2. Review of personnel health files indicated: A. RN N10 was hired 11/2/15, had documentation in their file that they were non immune to Rubeola (reference range = immune >29.9 and N10 had a level of <25.0), and had a hand written note that the RN "will get [MMR (measles, mumps, rubella)] after delivery 4/16". B. RN N13 first began work as a dialysis nurse at the facility on 1/28/14 and had no documentation of Varicella immunity or Hepatitis B history/declination in their file. 3. At 1:15 PM on 2/22/17, interview with HR (human resources director) staff member #55, confirmed that staff member N10 returned to work, after		**All human resources and employee health staff who participate in the new hire process were re-educated on Health Services policy 120 by the Human Resource Director during the month of February.** 2. How are you going to prevent the deficiency from recurring in the future? **All human resources and employee health staff who participate in the new hire process are educated on Health Services policy 120 during orientation, department meetings, and if and when policy changes.** **Employee Health Services educate all new hires on immunity status requirements during orientation and obtain information as indicated.** **Employee Health Services will monitor compliance outlined in the Pre-Employment Health Screen Policy. Communicable disease immunity status compliance will be audited monthly by employee health and presented at the Infection Control Meeting, Patient Safety, and up to the Quality Council and Medical Executive Committee.**	

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	delivery of their child, on 5/2/16, and no one followed up with the staff member to provide the MMR booster as required per the note in their personnel/health file. 4. At 1:40 PM on 2/22/17, interview with HR (human resources) staff member #64 confirmed that the dialysis nurse, N13, did not have Varicella or Hepatitis B information in their file.		3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Human Resource Director along with the Infection Control Nurse is ultimately responsible for the deficiency and overall and ongoing compliance.** 4. By what date are you going to have the deficiency corrected? **April 1, 2017**	
S 0608 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix) (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: (ix) Requirements for personal hygiene and attire appropriate for work settings.	S 0608	S608	04/01/2017

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	Based on document review, observation and interview, the infection control committee failed to ensure that surgical masks were removed after procedures for 2 of 2 surgical staff observed in the burn unit, staff members #67 and #68. Findings Include: 1. Review of the policy Surgical Department, policy number 4-220, last approved 1/2017, indicated under Procedure, A. Scrub Clothing...6. "Masks should cover both mouth and nose and be secured in a manner that prevents venting. When removing masks, touch only the strings, and removed (sic) after each procedure...". 2. At 11:15 AM on 2/20/17, while on tour of the burn unit in the company of staff members #54, the CNO (chief nursing officer), and a quality staff member, #53, it was observed that a surgery nurse (staff member #67) arrived on the unit with their surgical mask under their chin and a physician (#68) arrived on the burn unit with a surgical mask on but lifted it to take a drink of Gatorade and then placed it back down. 3. At 11:15 AM on 2/20/17, staff member #53 confirmed that facility policy requires the removal of a mask		1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **The involved staff were educated on surgical attire expectations, including masks outlined in the policy on February 20, 2017.** 2. How are you going to prevent the deficiency from recurring in the future? **All staff are educated on appropriate usage, donning and doffing of personal protective equipment as outlined in Infection Control Plan and expected adherence to appropriate practice during orientation, department rounds and annually. In addition, surgical staff and physicians are educated on Surgery department policy 4-22 including masks removing after procedures during orientation, department meetings, and if and when policy changes.** **Medical Staff were re-educated during medical staff committee meetings and one on one education during the month of March.** **Surgical Director will perform ten monthly audits for four consecutive months to ensure surgical attire**	

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	after each procedure and the surgery staff should not have arrived on the burn unit with masks already on, nor should the nurse have theirs under the chin, or the physician be lifting the mask to take a drink of something without changing to a different surgical mask.		**compliance, including appropriate use and removal of masks. The data will be presented at Infection Control, Patient Safety and up to the Quality Council and Medical Executive Committee.** 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Unit Nursing Managers along with the Infection Control Practitioner** 4. By what date are you going to have the deficiency corrected? **April 1, 2017**	
S 0610 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (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:			

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	(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on document review, observation and interview, the facility failed to monitor temperatures and maintain clean patient refrigerators in 6 of 11 (ICU, Endoscopy, Obstetrics, Burn, Medical Surgical, Recovery Room) areas toured. Findings Include: 1. Review of policy ADM 180, approved 4/2015, stated "1.1 Nutritional Services will be responsible for performing daily refrigerator/freezer checks on the patient refrigerators ...Using the Refrigerator/Freezer Temp Log nutritional staff will daily place a "dot" for the temperature reading ...". a. Review of the Daily Refrigerator Temperature Monitor in ICU, which was found hanging on the refrigerator, had 20 out of 51 days missing a dot in the January 1, 2017 to February 20, 2017 records.	S 0610	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **During survey, all refrigerator units were wiped down/cleaned per policy. Staff personal food was removed from patient unit per policy. Freezer units were defrosted. And staff were reminded who is responsible for cleaning the inside of the patient refrigerator units.** **Food and Nutrition Manager re-educated nutritional services staff on policy ADM 180 Patient Refrigerator/Freezer Temp Check/Documentation during the month of February and March.** **Food and Nutrition Manager re-educated nutritional services staff on policy 4001 which was approved November 2014 to clean thoroughly weekly and wiped down**	04/01/2017

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	b. Review of Floor Supply Work Sheet used by Nutritional Services to restock patient refrigerators, the patient refrigerator temperatures were documented Monday through Friday every week from January 1, 2017 to February 18, 2017. Missing all weekend days. 2. During tour on 02/20/17 from 11:00am to 12:30pm; 02/21/17 from 1:00pm to 3:30pm; and 02/22/17 from 9:35am to 11:16am, it was observed that 6 of 11 clinical areas (ICU, Endoscopy, Obstetrics, Burn, Medical Surgical, Recovery Room) had dirty (sticky residue, spots, crumbs) in refrigerators. 3. During tour of Endoscopy on 02/22/17 at 11:00am with A 4 - Quality Coordinator, A 5 - Chief Nursing Officer, A 15 - Operating manager, A 16 - Operating Room staff, an employee lunch container was found in the Patient Only refrigerator and the freezer component was completely iced over. 4. Interview on 02/21/17 at 1:00pm with A 12 - Infection Control, A 13 - Quality Registered Nurse, A 15 - Operating Room manager, A 16 - Operating room staff, A 4 - Quality coordinator, A 5 - Chief Nursing Officer and A 21 - Obstetrics and Medical		**daily patient refrigerator/freezer during safety huddle, unit meetings, and one on one education during the month of February and March.** **Nurse Manager re-educated endoscopy staff on policy IC 270 Consumption of Food and drink in patient care areas which include no personal food storage in patient refrigerator units during safety huddle, unit meetings, and in-services during the month of February and March.** **Facilities Manager re-educated maintenance staff on monitoring freezer units during monthly rounds and defrosting when indicated.** 1.How are you going to prevent the deficiency from recurring in the future? **Nutritional services staff are educated on daily monitoring and documenting temperatures and cleaning refrigerators/freezers during orientation, annually, and if and when policy changes. Food and Nutrition Manager will perform ten monthly audits for four consecutive months for patient refrigerator units.** **Endoscopy staff are educated on**	

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	Surgical manager confirmed that no one knew who was responsible for cleaning the inside of the patient refrigerators. 5. Interview on 02/21/17 at 1:30pm with A 4 - Quality Coordinator, indicated that a phone call with the Dietary manager confirmed that the patient pantry refrigerators are to be wiped out daily by dietary staff when restocking and there is no policy that states this.		**storage of personal food in designated areas such as staff break room refrigerators and informed non-designated patient care areas during orientation, annually, and if and when policy changes. In addition, No Personal Food signage was posted to reinforce expectation in February. Endoscopy Manager will perform ten monthly audits for four consecutive months.** **The audit data will be presented at the Infection Control Committee, Patient Safety and up to the Quality Council and Medical Executive Committee.** 1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Food and Nutrition Manager is ultimately responsible for the deficiency and overall and ongoing compliance for temperature and cleaning of refrigerator units.** **Nurse Manager is ultimately responsible for the deficiency and overall and ongoing compliance for personal food storage.** **Facilities Manager is ultimately responsible for the deficiency and overall and ongoing compliance for**	

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			defrosting freezer units. **The data will be presented at Infection Control, Patient Safety and up to the Quality Council and Medical Executive Committee.** 1.By what date are you going to have the deficiency corrected? **April 1, 2017**	
S 0712 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(1) (c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows: (1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information. Based on document review and interview, the facility failed to ensure the accuracy of consent forms for 1 of 1 patient who was a direct admission to the behavioral unit, Patient #2. Findings Include: 1. Review of the policy Medical Record Systems, policy number HIM 109, last	S 0712	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Unit reviewed additional consents for accuracy with no further action needed.** **Managers re-educated staff who are assigned to obtain consent forms on the Medical Record**	04/01/2017

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	approved 3/1/16, indicated in the Policy Statement: "The content of the medical record/data base for each patient shall be sufficiently comprehensive and detailed to foster high quality and continuity of care; meet the requirements of the legal and regulatory agencies...and the accrediting standards of agencies...". 2. Review of the policy Medical Record Documentation Review, policy number HIM 113, last approved 3/1/16, indicated in the Policy Statement: "Medical record reviews are performed on an ongoing basis to assure accurate, timely and legible completion of the patient's medical record...". 3. Review of the medical record for Patient #2 indicated: A. The patient was transferred from another facility ED (emergency department) for direct admission to the behavioral unit on 12/18/16. B. Page 3 of the "Consent (Registration)" form had a date of authentication by the witness, a social worker, of 12/8/16 at 1455 hours. C. The document "Notice of Communication Accessibility Services" was dated by the witness/social worker as 12/14/16 at 1458 hours. D. Page 2 of the Patient Rights & Responsibilities for the State of Indiana		**Systems policy number HIM 109 and the Medical Record Documentation Review policy HIM113, including ensuring accuracy of consent forms in February and during safety huddle, unit meetings, and in-services.** 2. How are you going to prevent the deficiency from recurring in the future? **Consents will be reviewed for accuracy by the person obtaining the signature for the consents. The consents will also be reviewed by registration when registering the patient.** **Direct admit patients' paperwork will be reviewed by the registration department for registration and verifying consents are correct.** **Registration and nursing staff who obtain general consents are educated on obtaining accurate consents during orientation annually, and if and when policy changes. Manager will perform ten monthly audits for four consecutive months.** **Registration Director will perform ten audits monthly to ensure accuracy of consents.** **The audit data will be presented at**	

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	form was dated 11/18/16 (the day is not clear, but appears to be 18) at 1456 hours by the witness/social worker. 4. At 12:00 PM on 2/21/17, interview with staff member #58, the infection and quality staff member, confirmed that: A. When a patient is being admitted directly to the behavioral health unit from another facility, the consents, patient rights, and other admission forms must be signed at the transferring facility prior to the arrival and admission at this facility. B. It was agreed that Patient #2 had never been admitted to this facility prior to 12/18/16 so that the prior dates on documents do not match any previous admission here. C. The dates consents/documents for Patient #2 were witnessed by the social worker at the transferring hospital were not accurate for the date of admission to this facility, 12/18/16. 5. At 12:05 PM on 2/21/17, interview with the manager of case management, staff member #66, confirmed that: A. Patient #2 came from another ED for direct admission to the behavioral health unit here. B. The consents/forms signed do not have the correct date of admission here on 12/18/16.		**the Patient Safety Committee and up to the Quality Council and Medical Executive Committee.** 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Registration Director is ultimately responsible for the deficiency and overall and ongoing compliance.** 4. By what date are you going to have the deficiency corrected? **April 1, 2017**	

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	C. It is unknown why the social worker/case management staff person at the other facility used 3 different (and incorrect) dates to witness a patient consent signature on 12/18/16.			
S 0912 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (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: (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			

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	nursing care and practice in all settings in which nursing care is provided in the hospital. Based on document review, observation and interview, the Blood Glucose Monitoring policy was not followed by nursing staff in 3 of 11 clinical areas (Wound Clinic, Obstetrics, Endoscopy) and failed to ensure that nursing staff followed the blood transfusion policy for 2 of 3 patients (P#16 and P#18). Findings Include: 1. Review of policy Nova Statstrip Whole Blood Glucose Monitoring System, PTC 110 approved 01/2017, stated in V. Equipment/Material/Reagents, C. Materials ..., b. "Opened StatStrip Control vials may be used for three (3) months after opening. The "expiration date may not exceed the manufacturers expiration date and MUST BE RECORDED ON THE VIALS" is stated in the policy. 2. During the tour on 2/20/17 at 11:50 am in the Wound Clinic in the company of A 4 - Quality Coordinator and A 5 - Chief Nursing Officer, control solutions #1 and #3 with 1/4/17 expiration dates written on the vials and test strips without an open date or an	S 0912	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Outdated Statstrip control vials and undated control vials were discarded during survey. Search included no additional identified stat strips were outdated.** **Nurse Managers re-educated clinical staff who perform glucose monitoring on Nova Statstrip Whole Blood Glucose Monitoring System policy PTC 110, including dating control strip vials and discarding expired control vials in February and March.** **Nurse Manager re-educated nursing staff who administer blood on policy Blood Transfusion NUR 280 during safety huddle, unit meetings, and in-services during the month of February and March including obtaining and recording pre transfusion vital signs per policy.** 1.How are you going to prevent the deficiency from recurring in the future? **Nursing staff are educated on**	04/01/2017

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	expiration date were observed. 3. During the tour on 02/21/17 at 1:45pm in Obstetrics in the company of A 4 - Quality Coordinator, A 5 - Chief Nursing Officer, A 21 - Obstetrics and Medical Surgical manager, a bottle of control solution (red #1) was noted as expired on 02/15/17. 4. Interview with A 4 - Quality Coordinator, A 5 - Chief Nursing Officer and A 21 - Obstetrics and Medical Surgical manager on 2/21/17 at 1:45 pm, confirmed that the control solution was outdated. 5. During the tour on 02/22/17 at 11:05am in Endoscopy in the company of A 4 - Quality Coordinator and A 5 - Chief Nursing Officer, a bottle of control solution (green #3) was noted as expired 02/07/17. 6. Interview with A 4 - Quality Coordinator, A 5 - Chief Nursing Officer, A 21 - Operating Room manager, and A 16 - Operating Room staff on 02/22/17 at 11:05 am, confirmed that the control solution was outdated. 7. Review of the policy Blood Transfusion, policy number NUR 280, last approved 11/2016, indicated on page		**Glucose Monitoring and Blood Administration during orientation, annually during skills lab, and if and when policy changes.** **Nursing Clinical Managers will perform ten monthly audits for four consecutive months to ensure compliance with expiration dates of control solution vials and test strips, and required vital signs for blood administration.** **Nursing Clinical Managers will perform ten monthly audits for four consecutive months to ensure compliance including documentation of required vital signs during blood transfusions.** **The data will be presented at Infection Control, Patient Safety and up to the Quality Council and Medical Executive Committee.** 1.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Nurse Managers are ultimately responsible for the deficiency and overall and ongoing compliance** 1.By what date are you going to have the deficiency corrected? **April 1, 2017**	

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	2, in section 4, that nursing is to: "Record baseline vital signs in the EMR (electronic medical record) or Transfusion Log Form before initiating transfusion..."; in section 5 that nursing is to: "Obtain the blood product..."; and in section 6 that nursing is to perform several checks with another nurse; in section 7 nursing it to attach the blood product to the "Y" infusion site; and in section 8. nursing is to begin the infusion. 8. Review of medical records indicated: A. Patient #16 had vital signs documented at 3:37am on 1/19/17 and the time of "Start" of the transfusion noted as occurring at 3:37am with no pre transfusion vital signs charted. B. Patient #18 had vital signs documented at 9:50pm on 12/9/16 and the time of "Start" of the transfusion noted at 9:50pm with no pre transfusion vital signs charted. 9. At 3:00pm on 2/21/17, interview with staff member #53, a quality staff person, confirmed that: A. Patient #16 had vital signs noted at 1:18am on 1/19/17 but that was too far out to be considered pre transfusion vital signs. B. Nursing entered the same time for the start of the blood transfusions for			

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	patients #16 and #18 as the vital signs were taken so that it cannot be determined that the vital signs were taken pre transfusion, as required per policy.			
S 1114 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(1) (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: (1) No condition in the facility or on the grounds shall be maintained which may be conducive to the harborage or breeding of insects, rodents, or other vermin. Based on observation and interview, the facility failed to ensure that no condition was present that was conducive to the harborage of insects in 3 areas toured. Findings Include: 1. While on tour of the Wound Clinic on 2/20/17 at 11:50 AM while in the company of the RN (registered nurse) manager, staff member #69, it was observed outside Room #3 that the	S 1114	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **During survey insects and bugs were removed from light fixtures in all three toured areas. Additional ceiling lights were observed and needs addressed.** **Facilities Manager re-educated staff on observing light fixtures during monthly Environment of Care rounds and clean fixtures at the**	04/01/2017

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	hallway lights (2 feet by 4 feet drop down light panels) had >50 small insects/bugs present in one light and >12 in two other light panels. 2. At 12:45 PM on 2/20/17, interview with staff member #56, the Support Services staff member, confirmed that: A. Insects were present in the lights. B. There is no routine cleaning of the lights, and no policy related to the cleaning of the lights in the facility. C. It is up to staff to complete a work order when it is noticed that the lights need to be cleaned. D. (It was later reported that the insects were gnats.) 3. At 10:10 AM on 2/22/17, while on tour of the surgical suite of the burn unit in the company of staff member #53, a quality staff member, it was observed that there were insects/bugs in 2 of the 4 (2 ft/4 ft drop down light panels) in the ceiling. (There was >3 in one light and one in the other light.) 4. Staff member #53 confirmed the presence of insects in the surgical room ceiling lights at 10:10 AM on 2/22/17. 5. At 10:45 AM on 2/22/17, while on tour of the post operative area of the facility surgery unit, in the company of a		**time of rounding rounds.** 2. How are you going to prevent the deficiency from recurring in the future? **Facilities staff are educated on completing monthly environment of care rounds including cleaning light fixtures during orientation and annually.** **Facilities Manager reminded Unit Managers to complete work orders when insects are noted in light fixtures during identified during departmental monthly rounds.** **Facilities Managers will perform ten monthly audits for four consecutive months to ensure compliance with light fixture cleaning.** **The data will be presented at Infection Control, Environment of Care, and up to the Quality Council and Medical Executive Committee.** 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Facilities Manager is ultimately responsible for the deficiency and overall and ongoing compliance.**	

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	quality staff member, staff person #53, it was observed that there were insects/bugs in the ceiling lights (2 lights) above the blanket warmer outside of bay #11 and in the lights between bays #1 and #2 and #3 and #4. 6. Staff member #53 confirmed the presence of insects in the post op area ceiling lights at 10:45 AM on 2/22/17.		4. By what date are you going to have the deficiency corrected? April 1, 2017	
S 1160 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1) (d) The equipment requirements are as follows: (1) All equipment shall be in good working order and regularly serviced and maintained. Based on observation and interview the facility failed to ensure that equipment was in good working order related to one handwashing sink in one burn unit. Findings Include: 1. While on tour of the burn unit at 11:25 AM on 2/20/17, in the company of the CNO (Chief Nursing Officer), staff member #52, it was observed that the motion activated handwashing sink in the	S 1160	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **During survey, a work order was placed to address the inoperable sink in the Burn Center and the repair was completed by March 1, 2017.** **Nurse Manager re-educated burn center staff to review equipment for needed repairs, and if and when**	03/01/2017

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	hydrotherapy room of the unit would not activate for use. 2. At 11:25 AM on 2/20/17, staff member #52 confirmed that the sink was inoperable. 3. At 12:30 PM on 2/20/17, interview with the Director of Support Services, staff member #56, confirmed that nursing staff must complete a work order for equipment, such as the burn unit sink, to be repaired/maintained.		**integrity within the equipment is compromised to place a work order during safety huddles, unit meetings, and one on one education during the month of February and March.** **Nurse Manager re-educated staff on the work order entry during February and March. Expectations were emphasized on placing work order if and when equipment need repaired including inoperable sink.** 2. How are you going to prevent the deficiency from recurring in the future? **The requirement to enter work order is reviewed during unit orientation. All burn unit clinical staff are educated on placing a work order if and when equipment needs repaired including when an inoperable sink is identified.** **Burn Nurse Manager will perform unit monthly environment of care audits for four consecutive months to ensure compliance with operable equipment. The data will be presented at Patient Safety and up to the Quality Council and Medical Executive Committee.** 3. Who is going to be	

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			responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Nurse Manager is ultimately responsible for the work order deficiency and overall and ongoing compliance.** 4. By what date are you going to have the deficiency corrected? **March 1, 2017**	
S 1162 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A) (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: (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule. Based on observation, document review and interview, the bio med staff failed to ensure the PM (preventive maintenance) of one SCD (sequential compression device) located on the burn unit.	S 1162	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.	03/29/2017

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	Findings Include: 1. While on tour of the burn unit, patient room #4, in the company of the CNO (Chief Nursing Officer), staff member #52, at 11:05 AM on 2/20/17, it was observed that the SCD pump (asset # L10480) in the closet had a PM sticker that indicated a PM check was due 11/2016. 2. Review of the PM Work Order for the SCD pump with asset # L10480 indicated the "Interval" of PM was every "12 mos. (months)". 3. Review of the Asset Detail Report indicated the last PM done for the SCD pump (L10480) was 11/25/15 at 2:56 PM. 4. At 3:40 PM on 2/21/17, interview with bio med staff member #57 confirmed that: A. The SCD pump had not had PM service since 11/2015 and should have been done in 11/2016. B. Notices asking about, and looking for, the equipment had been sent in e-mails to the nursing units with no response received. C. It was thought that the SCD pump was lost and was about to be removed		**Biomedical engineering corrected the discrepancy on asset number L10480 performing the required PM on 3/29/17 by tech under work order number 226508.** 2. How are you going to prevent the deficiency from recurring in the future? **Monthly notifications are communicated to Clinical Departments to assist with the search of locating missing equipment.** **Per Biomedical Engineering policy number EC.02.04.03.3.b, Biomedical Engineering will continue to search for equipment missing preventative maintenance for three months, notifying department heads and staff to assist us in the searches. If unable to locate the devices after three consecutive months of said process, the device is determined "LOST", and is removed from the scheduled PM list.** **Biomedical Engineering, under the guidance of the Biomed Tech Lead, is responsible for following up on ALL past due preventative maintenance. Past due PMs are reviewed monthly, searches are**	

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	from the asset list.		**performed, and emails notifying department heads and staff are sent to solicit their assistance in the searches. Biomedical Engineering is required to accomplish at least a 95% completion rating for all Medium/Low risk pieces of scheduled maintenance. Data is presented at Environment of Care and up to the Quality Council and Medical Committee.** 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Biomedical Engineering Lead is ultimately responsible for the biomedical deficiency and overall and ongoing compliance.** 4. By what date are you going to have the deficiency corrected? **3/29/17**	
S 1172 Bldg. 00	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			

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	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 document review, observation and interview, the facility failed to follow standards of practice as outlined in cleaning policies as evidenced by multiple areas of dust (refrigerators, blanket warmers, floors) noted throughout the touring of 11 clinical areas. Findings Include: 1. Review of policy ENV330, reviewed 2/2013, #1 Procedure 5. stated "High Dust: Start high dusting at the door of the room and proceed all the way around the room dusting horizontal ledges that are hard to reach. Make sure to dust vents ...". 2. Review of policy ENV520, reviewed 11/2015, #2 Patient Rooms 1. stated "All horizontal surfaces and furniture must be damp wiped daily".	S 1172	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Environmental services staff were re-educated on policy ENV330 on high dusting process and the ENV520 on damp wiping surfaces by the EVS Director. Burn Unit dried liquid splashes was wet wiped cleaned during survey. Hydrotherapy Blanket warmer was dusted. Floor pieces were removed. OB refrigerator was dusted 2. How are you going to prevent the deficiency from recurring in the future? Environmental Services Staff are educated on cleaning and dusting expectations during orientation, annually, and if and when policy changes. EVS Director will perform ten monthly audits for four consecutive months to ensure compliance with cleaning and dusting.	03/01/2017

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	3. During a tour at 11:10 am on 2/20/17, Room #4 in the Burn Unit was observed with footprints and dried liquid splashes on the floor. 4. During a tour at 11:22 am on 2/20/17 of the hydrotherapy room, the top of the blanket warmer was covered with dust, the floor had paper pieces and plastic present after having been cleaned. 5. During a tour at 1:25 pm on 2/21/17 refrigerator with dust on top in Labor & Delivery area and on top of the pantry refrigerator (by room 241). 6. During a tour at 2:20 pm on 2/21/17, the top of the blanket warmer in the equipment room of the Intensive Care Unit and the floor with dust, plastic and a 3X6 piece of paper. 7. During a tour at 2:25 pm on 02/21/17, rooms #3, #4 and #5 with dust on the window ledges of the doors to the patient rooms in Intensive Care Unit. 8. During a tour on 2-21-17 at 4:10 pm, in the company of the director of support services, staff A 7 and the director of quality and interim infection control (IC) nurse, staff A 12 the presence of a large number of (dead)		The data will be presented at Infection Control, Patient Safety and up to the Quality Council and Medical Executive Committee. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Environmental Services Director is ultimately responsible for the cleaning and dusting and overall and ongoing compliance.** 4. By what date are you going to have the deficiency corrected? March 1, 207	

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	insects was observed in a 2' x 4' light fixture in the clean linen storage room. 9. During a tour on 2-21-17 at 4:10 pm, in the company of the Director of Support Services, staff A 7 and the Director of Quality and Infection Control nurse, staff A 12 confirmed the presence of insects in the lighting fixture was unsanitary. 10. During a tour on 2-21-17 at 4:11 pm of the clean linen storage room, in the company of the Director of Support Services, staff A7 and the Director of Quality and Infection Control nurse, staff A 12 confirmed the presence of a gross amount of accumulated dust was observed on a 16" x 36" wall ventilation grille. 11. During a tour on 2-21-17 at 4:11 pm, in the company of Director of Support Services, staff A 7 confirmed the dusty ventilation grille was unsanitary. 12. During a tour on 2-21-17 at 4:13 pm of the clean linen storage room, in the company of the Director of Support Services, staff A 7 and the Director of Quality and Infection Control nurse, staff A 12 noted the presence of accumulated dust was observed on a 24' long row of 24" x 48" open shelving units containing			

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ST JOSEPH HOSPITAL	700 BROADWAY FORT WAYNE, IN 46802

(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
	a large quantity of scrub uniforms for use in the restricted surgical environment. 13. During a tour on 2-21-17 at 4:13 pm, the Director of Quality and Infection Control nurse, staff A 12 confirmed the dusty condition of the open shelving units for storing the surgery scrubs was unsanitary. 14. During a tour at 9:50 am on 2/22/17, in the company of the Director of Quality and Infection Control nurse A 12, dust on the wall air vents in the Burn Unit OR room was observed. 15. During a tour at 10:12 am on 2/22/17, in the company of the Director of Quality and Infection Control nurse A 12, dust on the wall air vents in the OB OR room was observed. 16. During a tour at 10:30 am on 2/22/17, in the company of the Director of Quality and Infection Control nurse A 12, dust on the base/lower ledges of the anesthesia machine in the surgery operating room #3 as observed. 17. Tours 1 through 5 and 12 through 14 were done with A 4 - Quality Coordinator, A 5 - Chief Nursing Officer present at all tours. They confirmed the dust seen in various parts of the 11			

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	clinical areas. 18. Tours 6 through 11 were done with A 7, Director of Support Services and A 12, Director of Infection Control where they confirmed the findings.			
S 1510 Bldg. 00	410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C) (b) The emergency service shall have the following: (2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following: (A) Provision for the care of the disturbed patient. (B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care. (C) Provision for transfer of patients when care is needed which cannot be provided. Based on document review and interview, the facility failed to follow policy ADM150 by not ensuring the completeness of the transfer	S 1510	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.	04/01/2017

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	documentation for 3 out of 6 patients (P14, P22, P23). Findings Include: 1. Review of policy ADM150, approved 12/2015 indicated on page 21 under Transfer Protocol, 1. A. ii. "Reason for Transfer and iii. Risk(s) of transfer" were to be documented. 2. Review of the following medical records indicated the following: a. P#14 lacked documentation for Benefits, Risks and Reason for Transfer in Section C; b. P#22 and P#23 lacked documentation of Reason for Transfer, in Section C. 3. Interview on 02/21/17 at 11:25 am, with A 20, Emergency Department manager and A 12, Infection Control nurse confirmed that the transfer forms were not completed as required by policy, ADM150.		**Review of identified medical records included documentation of reasons for the transfer.** **Emergency Room Manager re-educated emergency department nursing staff and Emergency Management physicians on policy Adm 150 EMTALA, and Transfer form to include documentation of reason for transfer during February and March.** **Chief of Emergency Management re-educated emergency management physicians on policy Adm 150 EMTALA, and Transfer form to include documentation of reason for transfer during the ED Operations meeting in February 2017.** 2. How are you going to prevent the deficiency from recurring in the future? **Nursing staff and Physicians are educated on EMTALA, and completion of transfer forms during orientation, annually, and if and when policy changes.** **Nursing Clinical Managers will perform ten monthly audits for four consecutive months to ensure compliance with Transfer form documentation.**	

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			The data will be presented at Patient Safety, Emergency Management Operations meeting and up to the Quality Council and Medical Executive Committee. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **Chief of Emergency Management along with the Nurse Manager** are **ultimately responsible for the deficiency and overall and ongoing compliance for transfer forms.** 4. By what date are you going to have the deficiency corrected? **April 1, 2017**	