STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	11/30/2016

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S 0000 Bldg. 00	This visit was for a Hospital State licensure survey. Facility Number: 005056 Dates: 11/28/16 to 11/30/16 QA: 01/06/2017 LH	S 0000		
S 0178 Bldg. 00	410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a) (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system. Based on observation and interview, the hospital failed to conspicuously post a copy of the hospital license at 2 off-site premises (OS5 and OS2). Findings: 1. On 11/29/16 between 3:15pm and 3:45pm, during tour of OS5, in the presence of A12, Practice Manager, it was observed that no copy of the hospital	S 0178	Copies of the hospital license have been made and will be conspicuously posted in all hospital clinics by 2/10/17. This will be done annually when the new license is received. The Manager of Regulatory/Risk and the Physician Practice Manager will be responsible.	02/10/2017

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

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	license was posted in an area open to patients and public. 2. On 11/30/16 between 9:00am and 10:00am, during tour of OS2, in the presence of A12, Practice Manager, it was observed that no copy of the hospital license was posted in an area open to patients and public. 3. On 11/29/16 between 3:15pm and 3:45pm, A12 verified that OS5 did not have a copy of the hospital license posted and on 11/30/16 between 9:00am and 10:00am, A12 verified that OS2 did not have a copy of the hospital license posted.			
S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to ensure	S 0406	1. A complete review of the Quality Assessment and	07/10/2017

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	that the quality assessment and performance improvement (QAPI) program was comprehensive for 9 services (audiology, ICU, radiology (including computed tomography, mammography, magnetic resonance imaging, nuclear medicine and ultrasound), medical records, outpatient services, sleep lab, inpatient surgery, outpatient surgery and off-site clinics) and hospital-wide for 1 service of the hospital (chiropractic) within the past 4 quarters. Findings: 1. Review of the Performance Improvement Plan, unable to determine approval date, indicated the following: a. This plan is carried out by...in an interdisciplinary, collaborative, hospital wide approach... b. The Performance Improvement Plan (PIP) is approved by the Governing Board (GB) at least biennially to assure adequate support and resources are available or appropriately allocated. c. When new programs or services are considered, or when a process requires modification an interdisciplinary review process is initiated. Each new process will set performance expectations... d. Measurement: A performance measure is used to determine whether the		Performance Improvement (QAPI) Program will be done to further examine areas of improvement. We will reach out to any necessary resources for assistance and guidance in restructuring our current program. Guidance and coaching will be given to the Quality Manager (QM) as the program is redirected in a more effective manner. We will generate a charter for a more clearly defined purpose of the Quality Council (QC). We will reestablish the proper flow of information and conduction of business through QC to Board Quality (BQ) and on to Board of Governors (BOG). The QC will oversee the audit and review of all departmental quality indicators to include inpatient, outpatient, ancillary, support services, and contractors. Audiology is a service line no longer offered and will not need to be included in the QAPI program. The comprehensive review will include, but not limited to ICU, Radiology and its subspecialties, HIM, Outpatient Surgery (including anesthesia), Infection Control, Housekeeping, Dietary, OB, Pharmacy, and Behavioral Health. Where appropriate, there will be criteria or numerator/denominator measures for the quality indicators. This will come from the audit and review process.	

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	process, function or service is performing according to the identified performance expectation... e. The Hospital uses established criteria to ensure that the data collected is appropriate for monitoring performance. f. The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable. e. The measure has defined data elements and allowable values. f. Components of the mentioned functions will be monitored across (hospital) programs and services offered at the (hospital). 2. Review of Quality Council Meeting minutes dated 1/18/16, 3/28/16, 4/25/16, 5/16/16, 6/27/16, 7/18/16, 9/28/16 and 10/31/16 lacked evidence of review or inclusion of multiple services and functions including chiropractic services. The minutes lacked evidence of monitor criteria or numerator/denominator measures for 15 services (anesthesia, dietary, emergency department (ED), housekeeping, intensive care unit (ICU), infection control, medication errors, obstetrics (OB), pharmacy, behavioral health (BHU), radiology, inpatient surgery, outpatient surgery, utilization review or clinics/off-sites)		2. By reestablishing the purpose and intent of QC, there will be better oversight from the QC in monitoring quality measures, data, and driving solutions for quality improvement. QC will be tasked with conducting business and affecting change in policies and procedures to improve all aspects of quality throughout the hospital. They will ensure that data and recommendations are forwarded on to BQ and BOG for review and approval. QC will provide both monitoring and support to the QM. 3. The execution of this plan will be carried by the QM, under the guidance and supervision of the Chief Medical Officer (CMO) and the Executive Leadership Team. 4. Within 30 days, by February 10, 2017, the QM will be given guidance, under the direction of the CMO, to develop a charter to outline the purpose, membership, and process of QC. This will be adopted and members will be selected to meet the QC. By April 10, 2017, the QM, under the direction of the CMO, will have drafted a PIP for 2017 for review and approval of QC. This will be forwarded to BQ and BOG as they next convene. By July 10, 2017, all departments of the hospital (inpatient and outpatient) will be compiled and divided into groups for review of their quality indicators. Each department will be assigned a date to meet with QC until all are	

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	3. Review of Patient Safety Committee minutes dated 1/14/16, 2/11/16, 3/10/16, 4/14/16, 5/12/16, 6/9/16, 7/18/16, 8/11/16, 9/8/16 and 10/13/16 lacked evidence of review or inclusion of multiple services and functions including chiropractic. The minutes lacked evidence of monitor criteria or numerator/denominator measures for 15 services (anesthesia, dietary, emergency department (ED), housekeeping, intensive care unit (ICU), infection control, medication errors, obstetrics (OB), pharmacy, behavioral health (BH), radiology, inpatient surgery, outpatient surgery, utilization review or clinics/off-sites) 4. Review of departmental quality reports for the past 4 quarters lacked evidence of any monitoring of the hospital's chiropractic services. The reports lacked clear documentation of set monitor statements/expectations, lacked documentation of numerator/denominator statements or description of the population to which the measure was applicable and lacked defined allowable values for 9 services(audiology, ICU, radiology (including computed tomography, mammography, magnetic resonance imaging, nuclear medicine and ultrasound), medical records, outpatient services, sleep lab, inpatient surgery,		completed.	

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	outpatient surgery and off-site clinics). 5. On 11/30/16 between 12:00pm and 4:00pm, A11, Quality Manager, indicated that the GB delegated all QAPI activities and approval of the PIP to the quality committee. A11 indicated the GB had not approved the PIP within the past 4 quarters. A11 indicated that the Safety Committee reports up through the Quality Committee and all minutes should be included in quality monitor review. A11 verified that quality monitor statements, data collection statements and numerator/denominator statements were not documented, that off-site monitors and data collection was combined without clear indication of individual site performance and that chiropractic services had not been included in the QAPI monitoring within the past 4 quarters.			
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 document review, observation and	S 0554	Education reminders on hand hygiene techniques will be done in all clinical areas of the hospital	02/10/2017

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	interview the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors by failing to follow facility policy/procedure for hand hygiene for 1 of 15 (Med/Surg Unit) areas toured. Findings: 1. Policy 4006, Hand Hygiene - CDC Guidelines, revised/reapproved on 04/15 indicated: A. (page 1), all staff shall use the hand-hygiene techniques, as set fourth in the following procedure. Before and after each patient encounter or contact with the patient's environment, i.e., bedside table, bedrails, etc. B. (page 2), before applying gloves. After coming in contact with patient's intact skin, i.e., taking a patient's blood pressure, pulse, lifting/moving the patient. 2. While on tour of facility on 11/28/16 at approximately 1515 hours, accompanied by staff N17(Med Surg Nurse Manager) and staff N18 (Infection Preventionist/Quality Improvement), staff N16 (CNA) was observed entering a patient's room, providing patient care and leaving a patient's room without performing hand hygiene. 3. Staff N17 and N18 were interviewed on 11/28/16 at approximately 1515 hours and confirmed staff N16 entered a patient's room,		by February 10, 2017. Department managers perform monthly hand hygiene checklists which are turned in to the Infection Control Nurse. The Infection Control Nurse also will complete hand hygiene monitoring during her monthly rounds. These results will be reported through the Infection Control Committee. Proper hand hygiene education is done for new employees during general orientation to the hospital. Ongoing annual education is done for current employees through the Healthsream education module. Department managers and the Infection Control Nurse will monitor for compliance.	

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	provided patient care and left the patient's room without performing hand hygiene. Staff N17 and N18 confirmed staff N16 should have followed facility policy/procedure for Hand Hygiene.			
S 0596 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (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: (iii) Cleaning, disinfection, and sterilization. Based on document review, observation and interview the facility failed to follow the policies/procedures for cleaning of equipment and supplies for 1 of 15 (Med/Surg Unit) areas toured. Findings: 1. Policy, Cleaning of Equipment and Supplies Not Requiring Sterilization, reviewed/revised on 01/16 indicated: all articles that are not sterilized are washed	S 0596	Education reminders on the cleaning of equipment between patients will be completed in all of the patient care areas by February 10, 2017. Department managers and the Infection Control Nurse will monitor staff in day to day operations to ensure that proper cleaning is taking place. The department managers and the Infection Control Nurse will monitor for compliance.	02/10/2017

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	with 10% bleach solution or bleach wipes. 2. Policy, Standard Precautions, reviewed/revised on 01/16 indicated: A. (page 6), patient-care equipment and instrument/devices: Established policies and procedures for containing, transporting and handling patient-care equipment and instruments/devices that may be contaminated with blood or body fluids shall be followed. B. (page 7), multi-use electronic equipment, including those items that are used by patients, items used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently shall be cleaned and disinfected on a daily basis. 2. While on tour of facility on 11/28/16 at approximately 1515 hours, accompanied by staff N17(Med Surg Nurse Manager) and staff N18 (Infection Preventionist/Quality Improvement), staff N16 (CNA) was observed entering a patient's room and obtaining vital signs without disinfecting equipment he/she had previously used in another patient's room. Equipment included a blood pressure cuff, pulse oximeter and thermometer. Staff N16 was observed utilizing equipment in patient rooms without disinfecting prior to or after use. 3. Staff N17 and N18 were interviewed on 11/28/16 at approximately 1515 hours and confirmed staff N16 entered a patient's room and obtained vital signs without disinfecting			

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	the equipment used previous in another patient's room. Staff N17 and N18 confirmed staff N16 should have followed facility policy/procedure for cleaning of equipment/supplies.			
S 0948 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(5) (c) Drugs and biologicals shall be prepared for administration and administered as follows: (5) In accordance with currently acceptable standards of practice. Based on document review, observation and interview the facility failed to ensure drugs are prepared for administration in accordance with current standards of practice for 1 of 4 (Operating Suite) areas toured. Findings: 1. Policy/procedure, Standard Precautions, revised/reapproved 01/2016 indicated on page 4: safe injection practices: use aseptic technique to avoid contamination of sterile injection	S 0948	Educational reminders for aseptic technique will be completed in all patient care areas by February 10, 2017. Department managers and the Infection Control Nurse will monitor for day to day compliance of staff. As this event occurred in the Surgery Department, the Surgery Director will monitor for compliance in her weekly rounds of the department for the next 90 days. There will also be education discussed at the monthly Anesthesia Department Meeting, as the person involved in the infraction was an anesthesia provider. Department managers, the	02/10/2017

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	equipment. 2. While on tour of facility on 11/29/16 at approximately 1100 hours, accompanied by staff N18 (Infection Preventionist/Quality Improvement) and Staff N19 (Director of Surgical Services), medical staff D1 (Physician) was observed preparing for administration of injectable medication without using proper aseptic technique practices including the lack of swabbing rubber diaphragm of vial. 3. Staff N18 was interviewed on 11/30/16 at approximately 1200 and confirmed staff D1 should have prepared and administered injectable medication using aseptic technique and confirmed all staff are to follow facility policy and procedure for safe injection practices.		Infection Control Nurse and the Surgery Director will monitor for compliance.	
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			

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	schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule. Based on document review, observation and interview, the hospital failed to ensure all mechanical equipment was on a documented maintenance schedule of appropriate frequency with the manufacturer's recommended schedule for 4 pieces of equipment (Emergency Generator, dietary dishwasher, sleep study machine, and steam sterilizer). Findings: 1. Review of documentation (http://www.midmark.com/docs/libraries provider6/pdfs/003-2707-99.pdf?sfvrsn=8) of the M9 UltraClave indicated daily cleaning, weekly and monthly maintenance (PM) were recommended. 2. Review of the emergency generator manual indicated preventive maintenance (PM) frequencies to include, but not limited to, every 6 months. 3. Review of the floor scrubber manual indicated periodic PM should include daily and bi-monthly maintenance. 4. Review of sleep study machine company representative letter documentation indicated the sleep study	S 1162	1. Clinic staff will be trained to perform daily and weekly maintenance items per the manufacturer's user manual. Daily and weekly maintenance will be performed and documented on a log sheet by the clinic staff. All monthly maintenance items in the manufacturer's user manual will be performed and documented by the Biomedical Technician. 2. The manufacturer was contacted for the latest revision of the maintenance recommendations and requirements for the facility generators. The documentation generated by the automated maintenance software system has been amended to reflect the current manufacturer recommendations as per the maintenance tables. 3. The manufacturer maintenance recommendations and requirements for the facility floor scrubbers indicated that the maintenance schedule is to be completed on a daily, weekly, semi-annual and annual basis. These recommended checks and services have been generated in the automated maintenance software system. The daily check will be implemented immediately upon the completion of staff training by January 27. 2017. 4. Per the manufacturers	02/10/2017

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	machine is recommended to undergo annual standard electrical safety testing. 5. On 11/30/16, between 9:00am and 10:00am, during tour of Off-site OS2, in the presence of A12, Practice Manager, a table top steam sterilizer (Ritter M9 UltraClave) was observed. The interior of unit contained packaged instruments. The water tube was yellowed with a whitish powder type substance/film noted near the top of the tube. Dusty type sediment was noted on the interior hinge of the door. 6. On 11/30/16 between 9:00am and 10:00am, during tour of Off-site OS2, S1, Certified Medical Assistant, indicated that clinic staff did not perform/document PM of any kind on the steam sterilizer. 7. On 11/30/16 at 11:45pm, A9, Director of Facilities Management, indicated the hospital did not have documentation of every 6 months emergency generator PM as per manufacturer recommendation. A9 agreed to provide a copy of the generator manufacturer recommended PM and the hospital policy. 8. On 11/30/16 at 1:00pm A14, Biomedical technician, indicated the manual for the dietary dishwasher nor the table top steam sterilizer, could not be		recommendation there is not a specific periodic maintenance required for Compumedics-Grael line of sleep study products. However, it is recommended that the Compumedics-Grael line of products undergo an electrical safety inspection on an annual basis. This is demonstrated in the maintenance work order system in December, 2016, this equipment was assigned a recurring electrical safety inspection that is due in December of each year. All electrical safety inspection records will be generated and documented in the automated maintenance software system. 5. As part of the scheduled preventative maintenance for the table top sterilizer , the Biomedical Technician will ensure that the unit is cleaned properly, the tubing in good condition, and any deficiencies found on the unit will be corrected. 6. All monthly, semi-annual, and annual maintenance procedures will be performed and documented but he Biomedical Technician. This piece of equipment will have a recurring monthly preventative maintenance (PM) assigned thorough an automated maintenance software system to the Biomedical Technician. The PM instructions list all maintenance items that are due to be performed as well as the scheduling of certain items for	

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	provided, and that the hospital did not have documentation of any PM for the dishwasher, and sleep study machine, and no documentation of regular PM/cleaning of the table-top steam sterilizer.		completion. An example would be the months the semi-annual maintenance needs to be performed. All preventative maintenance will be documented in the automated maintenance software system by the Biomedical Technician. The monthly PM cycle is scheduled to begin February 20, 2017. 7. The manufacturer was contacted for the latest revision of the maintenance recommendations and requirements for the facility generators and the attached documentation was provided. The documentation generated by the automated maintenance software system has been amended to reflect the current manufacturer recommendations as per the maintenance tables. 8. The manufacturer maintenance recommendations and requirements for the facility dishwasher indicate a semi-annual check which has been exceeded in the maintenance that has been completed. The equipment has a monthly check performed for basic operation and the prescribed semi annual as well. These recommended checks and services have been generated in the automated maintenance system software. The Director of Facilities or his designee will be responsible for the compliance of the above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150061	A. BUILDING 00 B. WING	11/30/2016

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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 current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on observation and interview, the hospital failed to ensure cleanliness of the facility in 2 locations (telecommunications room and diagnostic imaging). Findings: 1. On 11/28/16 between 1:45pm and 3:00pm during facility tour, in the presence of A3, Emergency Department Manager, and S3, Radiology Manager, the following was observed: In the radiology department computed tomography room, there was dust on top	S 1172	The cleaning of the telecommunications room was completed the second day of the survey. A new facility policy for cleaning will be written by February 10, 2017. The policy will address who is responsible for cleaning in all areas of the hospital. This policy will need to have approval at the next Safety Committee in February. Education will then be completed with hospital staff by the end of March, 2017. The Director of Facilities and/or his designee will monitor for compliance.	03/31/2017

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	of equipment surfaces. In the telecommunication room there were piles of heavy dust globules in room corners, wire clippings and other debris scattered across the floor. 2. On 11/28/16 between 1:45pm and 3:00pm S3 and A3 indicated housekeeping is responsible for cleaning all surfaces in the radiology rooms and that telecommunication technologist are responsible for maintaining cleanliness of their equipment room(s). 3. On 11/28/16 between 1:45pm and 3:00pm, policy for facility cleanliness was requested. The document was not received prior to exit.			