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	152012	A. BUILDING 00 B. WING	12/21/2016

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KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

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S 0000 Bldg. 00	This visit was for the investigation of one hospital licensure complaint. Complaint Number: IN00214587; Substantiated, deficiencies related to the allegations cited. Unrelated deficiencies cited. Date: 12/20/16 and 12/21/16 Facility Number: 008899 QA: 12/29/16 JL	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 facility failed to post their license in a conspicuous location that is open to patients and the public.	S 0178	Immediate Action: On 12-21-16 the DQM reviewed the standard with Hospital Administration. System changes: A License was posted on 5th and 6th floor nursing units in a common area.	12/21/2016

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

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	Findings Include: 1. At 11:55 AM and 1:25 PM on 12/20/16, while on tour of the 5th and 6th floor nursing units in the company of staff member #50, the CCO (Chief Clinical Officer), it was observed that the hospital license was not posted on the units for observation of patients and the public. 2. At 2:05 PM on 12/20/16, it was observed that the hospital license was posted in the Administrative offices of the hospital which is not easily accessible, or conspicuous, to patients and the public. 3. At 2:05 PM on 12/20/16, interview with staff member #50 confirmed that it was unknown that the hospital license was required to be posted conspicuously for patients and the public to view.		Monitoring: Licenses will be viewed monthly as part of EOC/Facility rounding for updates. Responsible party: Chief Executive Officer	
S 0322 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (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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	(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and interview the governing board failed to ensure the policy related to the Medicare IM (important message) form was implemented by having the form presented and signed within the appropriate time frame, per the facility policy, for 4 of 10 records reviewed, Patients #2, #8, #9 and #10; failed to ensure the policy related to Case Management assessments was implemented for 6 of 10 patients, Patient #4, #5, #7, #8, #9 and #10; and failed to ensure that a respiratory treatment was given at 8 AM the first day of admission, as ordered by the practitioner, for 1 of 5 current patients, Patient #4. Findings Include: 1. Review of the Financial Policies and Procedure Manual, section 2.0, Patient Admissions, page number 7 indicated in section 2.6 Admission Documents, that a) Required Inpatient Forms included the "Important Message from Medicare/Champus...", and on page 8. in section c); Explanation of additional forms required for Medicare patients: Inpatients - An Important Message from Medicare/Champus - This form shall be	S 0322	**Governing Board:** On 12-29-16, Leadership and Governing Board members had an ad hoc meeting following the exit of the survey team. The survey findings were reviewed, as well as the necessary elements and resources needed to ensure the plan of correction was in place. On 1-6-17, there was an additional meeting to ensure that all deficiencies cited were corrected. **IMM:** Immediate Action: On 12-21-16, the DQM reviewed the requirement and respective Financial Policies and Procedure Manual with all administrative leaders. System Change: On 12-22-2016 the Nurse Manager implemented a new process whereby a new patient packet is printed by the Unit Clerk (UC) for each new admission. All areas indicating a need for signature, date and time will be highlighted by the UC for a visual trigger. The admitting RN will be responsible for	01/20/2017

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	given to the patient within 2 calendar days of admission and be signed by the patient/representative. Follow-up copy of the form signed at admission shall be given to the patient within 2 calendar days of discharge...it is the responsibility of the DQM (director of quality management)/Admissions clerk to ensure that this information is accurate...". 2. Review of medical records indicated: A. Patient #2 was a current 72 year old patient admitted 12/5/16 who lacked a signature on the Medicare IM form in the chart. B. Patient #8 was an 89 year old admitted on 11/16/16 and discharged on 12/9/16 who lacked a Medicare IM form signed prior to discharge. C. Patient #9 was a 70 year old admitted on 11/3/16 and discharged on 11/25/16 who lacked a signed Medicare IM form at admission or at discharge. D. Patient #10 was a 67 year old admitted 11/10/16 and discharged 11/29/16 who lacked a date and time on the signed Medicare IM form to be able to determine if it was for the time of admission or discharge. 3. At 4:25 PM on 12/20/16 and 9:15 AM on 12/21/16, interview with staff member #51, a nurse manager, confirmed that documentation related to the Medicare		obtaining signatures, dates and times. The Director of Case Management receives a copy of the discharge IMM from the case managers within 2 days of discharge. An audit log was developed for tracking. Monitoring: All applicable inpatient records will be audited for admission and discharge IMM consent history and receipt signature, date and time. Monitoring will occur monthly x 3 months. Data to be reported at Facility Leadership Committee, Quality Council, Medical Executive Board and Governing Board. The need for additional monitoring will be determined by the Quality Council. Responsible Person: Chief Clinical Officer Resolved: 01-20-17 **Assessment Case Management:** Immediate Action: On 12-23-16, the Director of Case Management met with her team members to review and discuss the Financial Policies and Procedure manual, specifically pertaining to Admission Documents. The Director reinforced the importance of ensuring that psychosocial assessments are consistently	

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	IM was missing for patients #2, #8, #9 and #10, as listed in 2. above and not per facility policy. 4. At 3:00 PM on 12/20/16, 10:30 AM, 11:00 AM and 1:00 PM on 12/21/16, interview with the CCO (chief clinical officer), staff member #50, confirmed that the unit secretary is responsible for getting admission documents signed, except for the consent for admission and treatment forms and the Medicare IM form, in which RNs are responsible for getting these signatures at the time of admission. 5. Review of the policy Assessment/Re-Assessment-Interdisciplinary Patient, policy number H-PC 02-001 PRO, last released/approved 6/2016 indicated on page 7 in item 11.: "Case Management/Social Service Department a. Case Management/Social Services Department assesses all patients admitted to Kindred Hospital. InterQual and intensity of Service assessment is completed within 2 business days of admission...". 6. Review of medical records indicated: A. Patient #4 was admitted on 12/15/16 and had no Case Management/Social Services assessment in the chart. B. Patient #5 was admitted on 11/23/16		performed and documented within 2 business days of admission, per policy. System Change: The variance in staffing has been resolved. The District Director of Case Management is available to support or provide assistance as needed to ensure psychosocial assessments are completed per policy. Monitoring: New patient records will be audited for initial assessment completion monthly x 3 months. Data to be reported at Facility Leadership Committee, Quality Council, Medical Executive Board and Governing Board. The need for additional monitoring will be determined by the Quality Council. Responsible person: Director Case Management Resolved 01-20-17 **Respiratory (Medication Orders):** Immediate Action: On 12-22-16, Administrative and Clinical leaders met to review The Medication Reconciliation Policy and to discuss potential gaps with medication triggers for respiratory therapy in the absence of a pharmacist during off-shifts.	

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	and had the first Case Management notes as part of the IDT (interdisciplinary team) meeting on 11/29/16. C. Patient #7 was admitted on 11/6/16 and had a first Case Management note written on 11/10/16. D. Patient #8 was admitted on 11/16/16 and had a first Case Management note written 12/2/16. E. Patient #9 was admitted on 11/3/16 and had the first Case Management note written on 11/8/16. F. Patient #10 was admitted on 11/10/16 and had the first Case Management note written on 11/28/16. 7. At 11:55 AM on 12/21/16, interview with the director of Case Management, staff member #57, confirmed that: A. The patients listed in 6. above did not have assessments completed within 2 business days of admission, as required per facility policy. B. The Case Management department has not been at full staffing to be able to complete assessments timely. 8. Review of the policy Medication Reconciliation, policy number H-MM 03-005 PRO, last released/approved 6/2016 indicated on page 2 in item 4. that "The pharmacist shall provide a final review and verification (step 3) of Medication Reconciliation on all new		System Change: Beginning 12-23-16, nursing staff began putting in a 1 time order (with start time) for all respiratory medications that are new orders and that occur during pharmacy off hours. This process will ensure an electronic trigger for respiratory staff. Daily rounding and education is being carried out by the shift supervisors each shift. Compliance issues will be discussed at morning daily huddles. On 01-4&5-2017, education was provided on all nursing units with a visual aid to provide step by step instructions. Nursing leadership will continue to educate staff that were not present during these huddles. Monitoring: All respiratory medication orders are being monitored for timeliness and accordance with physician orders. Audits will be completed monthly x 3 months. Data to be reported at Facility Leadership Committee, Quality Council, Medical Executive Board and Governing Board. The need for additional monitoring will be determined by the Quality Council. Responsible Person: Chief Clinical Officer Resolved: 01-20-17	

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	admissions within 48 hours of admission...". 9. Review of medical records indicated Patient #4 was admitted on 12/15/16 at 11:45 PM, had an order written at 12:13 AM on 12/16/16 for an Albuterol nebulizer treatment to be given qid (four times a day) to start at 8 AM on 12/16/16, and did not receive the first nebulizer treatment until 12:06 PM on 12/16/16. 10. At 9:50 AM on 12/21/16, interview with a respiratory therapist, staff member #54, confirmed that: A. A respiratory treatment will not show up in the therapist's "worklist" (in the computer) until a pharmacist has "released" the order by doing their medication reconciliation process. B. Patient #4 did not receive their first 8 AM Albuterol nebulizer treatment as ordered by the physician. 11. At 10:15 AM on 12/21/16, interview with a pharmacist, staff member #60, confirmed that: A. A pharmacist arrives daily at 7 AM and first begins reconciliation for patients admitted the previous evening/night. B. Nursing is allowed to give medications by over riding the system if a medication has not yet gone through the reconciliation process by pharmacy staff,			

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	but Respiratory Therapists won't even see an order until the process has been completed. C. The Albuterol nebulizer order for patient #4 went through the medication reconciliation process at 8:06 AM on 12/16/16 but did not show up for delivery by respiratory therapy until the 12:00 PM dose so that the 8 AM dose was missed.			
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, observation and interview, the infection control committee failed to ensure there was an active and effective implementation of requirements for standard/contact precautions for staff entering 3 patient rooms on the 5th floor in which patients were noted to be on contact precautions, rooms 5201, 5220 and 5221, and two rooms on the 6th floor, rooms 6207 and	S 0556	Immediate Action: On 12-21-17, all current patients in house were reviewed to verify that they were in the appropriate isolation status as well as the correct signs posted. On 12-23-16, Leadership met and reviewed the Policy on Transmission Based Precautions. A communication	01/20/2017

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	6218. Findings Include: 1. Review of the policy Transmission-Based Precautions, policy number H-IC 02-002 PRO, last approved 8/2016 indicated under Procedure: "...2. If an infection appears to be present the recommended appropriate transmission based precautions should be executed at that time... 4. Post the appropriate precaution signage visible outside patient room...". And on page 6 under section G. "Duration of isolation (sic) for Patients with Identified MDRO's (multi drug resistant organisms): a) Patient with positive cultures for MDRO typically remain in precautions for the duration of their present admission...". 2. While on tour of the 5th floor nursing unit at 11:55 AM on 12/20/16 in the company of the chief clinical officer, staff member #50, it was observed that: A. Staff (a rehab tech, staff member #55) was in a posted contact isolation room (5201) with no gown on. B. 2 staff members (1 nurse, staff member #59 and one respiratory therapist, staff member #54) were observed in an isolation room (5221) with no PPE (personal protective equipment) on. C. 1 physician (staff member #58) was		went out to all leaders regarding appropriate PPE policy/process. Leaders were given a copy of the PPE guidelines and instructed to advise all of their staff of the guidelines in the policy, as well as the need for immediate resolution when a defienciency is found with a staff member or physician. Re-education and expectations were reinforced with the Infection Prevention Coordinator regarding daily monitoring of culture results and daily rounding for accurate signage as indicated based on cultures. In addition, secret shoppers were re-educated regarding the policy and expectations. System Change: The PPE and Isolation sign audit tool was revised to be inclusive of appropriate signage. On 1-12-2017, the new PPE auditing tool was sent to all leaders by the nursing manager. The Infection Control Coordinator or designee will monitor culture results daily to ensure accurate proper transmission based precautions and signage are in place. Appropriate signage as well as PPE protocol was discussed at the unit staff meetings held on January 4th and 5th. Nursing Leadership will follow up with any staff members not present at the unit staff meetings. PPE donning for	

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	observed in an isolation room (5220) with no PPE on. 3. At 11:55 AM on 12/20/16, staff member #50 confirmed that the staff listed in 2. above were all in contact precaution rooms without the appropriate PPE. 4. While on tour of the 6th floor nursing unit in the company of staff member #50 at 1:25 PM on 12/20/16, it was observed that: A. There was no contact precaution signage on the door to room 6207 but staff was wearing PPE to enter. B. 1 dietary employee failed to sanitize their hands prior to gloving and gowning to deliver a meal tray to room 6218 which had a contact precautions sign on the door. 5. Review of the medical record for the patient in room 6207 indicated they had lab cultures that were positive for CRE. 6. At 4:25 PM on 12/20/16, interview with nurse manager, staff member #51, confirmed that patient #5 had CRE and should have had contact precautions signage posted on the door of their room. 7. At 12:50 PM on 12/21/16, interview with the infection control preventionist		physicians will be discussed at the next MEC meeting to be held on January 31, 2017. Monitoring: Monthly auditing began on 12-23-16 for PPE compliance. Secret shoppers will monitor donning for appropriate PPE respective to identified patient isolation. All care givers entering rooms will be monitored to include contracted personnel and physicians. Culture reports are reviewed weekly during interdisciplinary conference meetings to ensure patients are placed in the correct isolation precautions. Audit will be completed monthly x 3 months. Data to be reported at Facility Leadership Committee, Quality Council, Medical Executive Board and Governing Board. The need for additional monitoring will be determined by the Quality Council. Responsible Person: Chief Clinical Officer Resolved: 01-20-17	

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	(ICP), staff member #61, confirmed that: A. They have only been the ICP since October 2016. B. They have not been monitoring the appropriateness of signage for patients on contact or other types of precautions. C. Staff have not been tracked or observed for appropriateness of PPE when entering patient rooms of those in isolation/precautions.			
S 0754 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. Based on document review and interview the facility failed to ensure that consents for admission and treatment were signed, per the facility policy, by 4 of 5 current patients or their representative, Patients #2, #3, #4 and #5.	S 0754	Immediate Action: On 12-21-16, administrative leaders met and reviewed the consent requirement and respective Financial Policies and	01/20/2017

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	Findings Include: 1. Review of the Financial Policies and Procedure Manual, (no approval date noted), section 2.0, Patient Admissions, page number 6 indicated in section 2.5 Patient Admission, section c) Completing Admission Forms that "...Ensure that all fields are completed on admission documents and that the documents are signed by the patient/representative upon admission. Notify Controller/designee when signatures cannot be obtained and document reason...a) After Hours Admission When Admissions Clerk/designee is not available, the Nursing supervisor/designee shall register the patient in Meditech through the After Hours Admission routine to create the Protouch registration and allow for immediate medical record documentation...". 2. Review of current patient medical records indicated: A. Patient #2 was admitted on 12/5/16 and lacked a signed consent for admission and treatment. B. Patient #3 was admitted on 10/4/16 and lacked a signed consent for admission and treatment. C. Patient #4 was admitted on 12/15/16 and lacked a signed consent for admission and treatment.		Procedure Manual. All patients in house were reviewed to ensure that a signed consent for treatment had been obtained. If consent could not be obtained, Nursing Leadership followed up with the appropriate person to sign consent for completion. System Change: On 12-22-2016 the Nurse Manager implemented a new process whereby a new patient packet is printed by the Unit Clerk (UC) for each new admission. All areas indicating a need for signature, date and time will be highlighted by the UC for a visual trigger. The admitting RN will be responsible for obtaining signatures, dates and times. An audit log was developed for tracking. Monitoring: All applicable inpatient records will be audited for admission consent. Records will be audited for receipt signature, date and time. Audits will be completed monthly x 3 months. Data to be reported at Facility Leadership Committee, Quality Council, Medical Executive Board and Governing Board. The need for additional monitoring will be determined by the Quality Council. Responsible Person: Chief Clinical Officer Resolved: 01-20-17	

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	D. Patient #5 was admitted 11/23/16 and had consents signed by the family but lacked a witness signature and a date or time of family authentication. 3. At 4:25 PM on 12/20/16 and 9:15 AM on 12/21/16, interview with staff member #51, a nurse manager, confirmed that documentation was lacking for consents for patients #2, #3, #4 and #5 as listed in 2. above. 4. At 3:00 PM on 12/20/16, 10:30 AM, 11:00 AM and 1:00 PM on 12/21/16, interview with the CCO (chief clinical officer), staff member #50, confirmed that the unit secretary is responsible for getting admission documents signed, except for the consent for admission and treatment forms and the Medicare IM form, in which RNs are responsible for getting these signatures at the time of admission.			
S 0926 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(1) (b) The nursing service shall have the following: (1) Adequate numbers of licensed			

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	152012	A. BUILDING 00 B. WING	12/21/2016

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KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

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	registered nurses, licensed practical nurses, and other ancillary personnel necessary for the provision of appropriate care to all patients, as needed, to include the immediate availability of a registered nurse. Based on document review and interview the nursing executive failed to implement the facility staffing guidelines grid for portions of a three week period in November for the 5th and 6th floor nursng units. Findings Include: 1. Review of the document "Staffing Guidelines", no policy number, dated 6/26/16 indicated that for the 5th floor 5 RNs (registered nurses) and 3 CNAs (certified nursing assistants) are to be scheduled on the day and night shift for 22 or more patients and for 22 or more patients on the 6th floor, there are to be 4 RNs and 3 CNAs scheduled on both shifts for 22 or more patients. 2. Review of the staffing for the 5th floor for the week of 11/6/16 to 11/12/16 indicated that on 11/9 and 11/11/6, there were only 2 CNAs with 22 patients present each day and on 11/9, 11/10, 11/11 and 11/12/16 there were only 2 nurse aides on the night shift with 22 patients present each day. 3. Review of the staffing for the 5th floor	S 0926	Immediate Action: On 12-23-16, the Patient Classification System policy was reviewed by administration. The CCO reviewed 15 dates listed within the SOD. It was determined that all 15 days had adequate staffing plans based on the Kindred Hospital Acuity Tool (KHAT) and in combination with the "Staffing Guideline" utilized at the time of the complaint. System Change: All staffing leaders were made aware and re-educated on the Patient Classification System Policy as it relates to appropriate staffing. Staffing is being reviewed daily by the CCO or designee to ensure that staffing is based on patient need in conjunction with the Patient Classification Policy. The Electronic KHAT staffing form is being attached to the daily staffing assignment logs for reference. Monitoring: The CCO or designee is reviewing staffing assignments daily to ensure appropriate staffing according to patient need. Monthly reports are being analyzed to identify variances in staffing. Staffing data will be	01/20/2017

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	for the week of 11/20/16 to 11/26/16 indicated 11/23/16 had 23 patients with only 2 CNAs scheduled for both the day and night shift. 4. The 6th floor census for the week of 11/6/16 to 11/12/16 had a census of 23 each day. The day shift staffing lacked the required number of aides on 11/7/16, 11/8/16 and 11/9/16 when only 2 were staffed, with the guidelines indicating 3 were to be scheduled. 5. The week of 11/13/16 to 11/19/16 for the 6th floor indicated the census was 22 or 23 all week. The night shift on 11/16/16, 11/17/16, and 11/18/16 had only 2 nurse aides scheduled when the guidelines indicated that 3 were to be staffed for that census number. 6. The week of 11/20/16 to 11/26/16 for the 6th floor indicated there was a census of 22 to 24 patients. The day shifts on 11/22/16 and 11/23/16 had only 2 nurse aides with the census on the 22nd being 23 and on the 23rd being 24 patients so that 3 nurse aides were required. The night shifts on 11/20/16 and 11/24/16 had only 2 nurse aides with the 20th having 22 patients and the 23rd having 24 patients and both shifts requiring 3 nurse aides, per the staffing guidelines document.		presented in Leadership committee, Quality Council, Medical Executive Committee and to the Governing Board. Responsible Person: Chief Clinical Officer Resolved: 01-20-17	

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	7. At 1:00 PM on 12/21/16, interview with the CCO (chief clinical officer), staff member #50, confirmed that the acuity of patients is also considered when staffing the 5th and 6th floor nursing units, and not just the staffing grid. The facility "may cut back on the number of aides" with a lower acuity of patients "for budgetary reasons".			
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 document review, observation and interview, the facility failed to ensure that a clean facility was maintained in	S 1172	Immediate Action: On 12-21-16 Administration met with the	01/20/2017

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	one patient room that was reported to be ready for a patient admission, room 5203, and related to hallway ceiling lights, a portable vital signs monitor and a supply room. Findings Include: 1. Review of the policy Terminal Cleaning of a Patient Room, policy number HD: H-HC 02-011, last approved 5/2015, indicated under "Rationale": "Patient rooms are thoroughly cleaned and disinfected following termination of occupancy by transfer or discharge...Terminal cleaning is completed before another patient is admitted or transferred to that room...Terminal cleaning of a patient room includes window sills, furniture, bed, bathroom (toilet, handrail, sink, shower/tub, and bathroom fixtures), inside bedside drawers and over-bed drawer, light switches, door handles, floor, etc.." Under Procedure on page 3 indicated cleaning staff was to: "...6. Remove disposable items, placing them in a plastic bag to be discarded, empty trash including biohazard trash, and remove from room...8..a. Dust and wipe down all ceilings and walls...d. Be sure to wipe/dust everything shoulder high and above...". 2. At 11:55 AM on 12/20/16, the 5th		Housekeeping Supervisor and reviewed the contracted services and the terminal cleaning policy. Room 5203 underwent a deep cleaning the same day. The room was blocked off for a leak repair as well as tile repair. The call light was replaced and confirmed in working order. System Change: A deep cleaning schedule was developed for all rooms and will be tracked on a cleaning log. Housekeepers are leaving signage indicating that the room is cleaned and ready for patient occupancy on the bed versus the door. Housekeepers will no longer clean patient rooms until all cabinets are displayed with doors open and empty contents indicating readiness to clean. Monitoring: Visual monitoring occurs during Weekly EOC rounds and follow up with EOC Committee. Responsible person: Chief Executive Officer Resolved: 01-20-17 <u>Ceiling Lights:</u> Immediate Action: On 12-21-16, the COO notified the Housekeeping Supervisor that the ceiling lights were identified as having bugs. The ceiling lights were thoroughly cleaned the	

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	floor nursing unit was toured in the company of staff member #50, the CCO (chief clinical officer) and the following was observed: A. Room 5203 was reported to have been cleaned and ready for the next patient with the following issues noted: a. There was dust and debris noted on the floor as one entered the room and in corners of the room where housekeeping had failed to mop the floor sufficiently. b. There was a dried splash noted on the ceiling above the bed (approx. 12 inches in diameter) and dark stains observed in the crevices between several ceiling tiles. c. There was an accumulation of dust on the top of a wall mounted cork/communication board. d. There was trash present in a receptacle which included IV bags and tubing. e. One of the two call lights in this private room did not work. f. The louvered wall mounted air vent on the wall behind the bathroom toilet had an accumulation of dust present. g. The toilet had a leak when flushed, with water spraying out from a joint/gasket. h. Wall tile were protruding and not flush on the wall behind the toilet. B. At 1:20 PM on 12/20/16, it was noted that the drop down ceiling lights in		same day. The cleaning policy was reviewed by administration and the Housekeeping Supervisor. System Change: A log book was developed by the Housekeeping Supervisor. Lights are cleaned bi-annually and will be documented on the log. Housekeeping will provide a copy of the log with each cleaning Monitoring: Visual monitoring occurs during Weekly EOC rounds and follow up with EOC Committee meeting. Responsible person: Chief Executive Officer Resolved: 01-20-17 <u>Supply Room:</u> Immediate action: On 12-21-16, the Housekeeping Supervisor was notified and the supply room was thoroughly cleaned. The cleaning policy was reviewed by administration and the Housekeeping Supervisor. System Change: On 12-27-16, housekeeper assignments were restructured. There will be 1 housekeeper assigned to clean the core areas. The person cleaning core areas will not be assigned any peripheral areas of the hospital.	

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	the hallway outside rooms 5220 and 5221 had bugs present with one having 12+ present. 3. At 11:55 AM, 12:45 PM and 1:20 PM on 12/20/16 the CCO, staff member #50, confirmed that: A. Room 5203 had a note on the door that it had been terminally cleaned and was ready for admission of the next patient. B. Room 5203 was not cleaned as per facility policy and expectations and conditions were found to be as listed in 2. above. C. At 12:45 PM, it was noted that the ceiling was being mopped (with a long handled tool) by housekeeping staff and the "splash/stain" was removable as were the black areas in the ceiling tile crevices. 4. At 1:25 PM on 12/20/16, the 6th floor nursing unit was toured in the company of staff member #50 and the following was observed: A. The base unit of the B/P (blood pressure) monitor on wheels (in the hallway by the nursing station) was noted to be dirty and with a substance that resembled dried Betadine. B. The supply room had dust present under the rolling supply carts as well as wrappers and shoe covers noted to be on the floor under the carts.		Monitoring: Visual monitoring will occur during Weekly EOC rounds and follow up with EOC Committee meetings. Responsible person: Chief Executive Officer Resolved: 01-20-17 <u>Blood pressure monitor:</u> Immediate action: On 12-21-16, the blood pressure monitor was thoroughly cleaned. All equipment was inspected for cleanliness. The Nurse Manager reviewed the cleaning protocol with the unit staff. System Change/Action: Information added to Nursing unit huddles .The COO reiterated that equipment is to be cleaned between each patient. Monitoring: Visual monitoring occurs during Weekly EOC rounds and follow up with EOC Committee. The Nursing Supervisor is monitoring during rounds each shift Responsible person: Chief Executive Officer Resolved: 01-20-17	

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	5. At 1:25 PM on 12/20/16, staff member #50 confirmed the conditions noted in 4. above. 6. At 12:15 PM and 1:50 PM on 12/20/16, interview with the contracted EVS (environmental services) director, staff member #53, confirmed that: A. Ceilings are not on a cleaning schedule and are not washed with terminal cleaning. They are only washed "when requested", and it was unknown when the ceiling of 5203 had last been cleaned. B. There is no log of cleaning for the drop down hallway ceiling lights, they are not on a "set schedule" for cleaning. C. There is one staff member per day who cleans the "core area" of each floor. The supply room daily cleaning is considered part of the core cleaning.			