

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/22/2015
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NAME OF PROVIDER OR SUPPLIER  ST VINCENT SALEM HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Dates of survey: 9/21/15 to 9/22/15  Facility number: 005087  QA: 09/28/15 JL	S 0000		
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 quality assurance and performance improvement (QAPI) program failed to include 10 directly provided services (computed tomography (CT) scan, endoscopy, infusion therapy, magnetic resonance imaging (MRI), ophthalmic surgery, pediatrics, peripherally inserted central catheters	S 0406	Rhea Goen, Quality Clinician, will meet with all Service Lines and Functions within the facility. At least one quality monitor will be chosen and submitted to the QA committee on a quarterly basis. This information will then go to the Medical Executive Committee and then to the Board of Directors. All new Service lines and Functions will go through the	11/01/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>(PICC), post-operative recovery, inpatient rehabilitation, and outpatient surgical service) and 4 contracted services (biomedical engineering, biohazard waste hauler, teleradiology, and security) in its evaluations for 1 facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the document titled Performance Improvement Plan 2015 (Quality Review), indicated This Performance Improvement Plan encompasses all key functions of care and services provided. The plan was approved 9/2015.</li> <li>2. Review QAPI reports for 2014/2015 lacked evidence of evaluation of the directly provided services of computed tomography (CT) scan, endoscopy, infusion therapy, magnetic resonance imaging (MRI), ophthalmic surgery, pediatrics, peripherally inserted central catheters (PICC), post-operative recovery, inpatient rehabilitation, and outpatient surgical service and the contracted services of biomedical engineering, biohazard waste hauler, teleradiology, and security.</li> <li>3. On 9/22/15 at 12:10pm, A13, Quality, indicated the 10 directly provided</li> </ol>		same process. No new policies will be needed.		

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S 0408 Bldg. 00	<p>services of computed tomography (CT) scan, endoscopy, infusion therapy, magnetic resonance imaging (MRI), ophthalmic surgery, pediatrics, peripherally inserted central catheters (PICC), post-operative recovery, inpatient rehabilitation, and outpatient surgical service and the contracted services of biomedical engineering, biohazard waste hauler, teleradiology, and security had not been included in the program evaluations.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</p> <p>(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:</p> <p>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC</p>			

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S 0592 Bldg. 00	<p>15-1.5-5(b)(3)(L)(i). Based on document review and interview, the quality assurance and performance improvement (QAPI) program failed to evaluate 2 functions (discharge planning and transcription) for 1 facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the document titled Performance Improvement Plan 2015 (Quality Review), indicated This Performance Improvement Plan encompasses all key functions of care and services provided. The plan was approved 9/2015.</li> <li>Review QAPI reports for 2014/2015 lacked evidence of evaluation of the function of discharge planning and the function of transcription.</li> <li>On 9/22/15 at 12:10pm, A13, Quality, indicated the functions of discharge planning and transcription had not been included in the program evaluations.</li> </ol> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p>	S 0408	Rhea Goen, Quality Clinician, will meet with all Service Lines and Functions within the facility. At least one quality monitor will be chosen and submitted to the QA committee on a quarterly basis. This information will then go to the Medical Executive Committee and then to the Board of Directors. All new Service lines and Functions will go through the same process. No new policies will be needed.	11/01/2015	

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	<p>(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:</p> <p>(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:</p> <p>(i) Sanitation. Based on observation and document review, the facility failed to ensure patient rooms were thoroughly cleaned between patients for 1 of 2 empty patient rooms.</p> <p>Findings include;</p> <p>1. During tour of the medical surgical unit beginning at 10:45 a.m. on 9/22/15 patient room #176 was identified by staff as cleaned and ready for patient admission. The bathroom contained an I.V. (intravenous) bag of solution draining in the bathroom sink.</p> <p>2. Facility policy titled "Cleaning After Patient Discharge" last reviewed/revised 2/15 states under procedure on page 1: "A. Nursing staff will strip room. 1. a. Prepare room for housekeeping to clean unit, by placing IV bags trash,</p>	S 0592	Mia Williams, Manager of IP services, and Shelley Fultz, Infection Control Nurse are responsible for this citation. All Medical-Surgical associates will be re-educated on policy, "Cleaning after patient Discharge". Infection Control nurse will do random checks on rooms after cleaning. All results will be reported to the IP Manager, who will report results to Quality Committee. The IV bag was removed during survey and the entire room was re-cleaned. All staff education will be completed by 11/1/15.	11/01/2015	

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S 0596 Bldg. 00	<p>magazines..... in wastebaskets....." Page 2 states: "B. Housekeeping staff.....v. Clean entire restroom."</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(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:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and staff interview, the facility failed to ensure MetriCide high-level disinfectant was used according to manufacturers recommendations and facility policy and failed to maintain logs and policy that complied with manufactures recommendations for 1 surgery department.</p> <p>Findings include;</p> <p>1. Facility policy titled "MetriCide" last</p>	S 0596	<p>Brittney Garloch is responsible for this plan of correction. At the time of the survey, only one policy was shared with the ISDH. There was a 2nd policy that should have been shared, "MetriCide Plus". In this policy it states that the 5 min and 12 min immersion times are correct.</p> <ul style="list-style-type: none"> <li>· Will add immersion in/out times to MetriCide log for verification of correct immersion times (completed by Oct. 31st)</li> <li>· Will add signage to MetriCide and MetriCide OPA Plus bins for easy referencing guidelines</li> </ul>	11/07/2015

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	<p>reviewed/revised 8/14 states under policy on page 1: ".....an immersion time of at least 45 minutes."</p> <p>2. Manufacturers recommendations for MetriCide indicates the following: (A) The concentration of your MetriCide OPA Plus Solution must be verified by a MetriCide OPA Plus Solution Test Strip prior to each use....." and ".....Soak instruments in MetriCide OPA Plus Solution for 12 minutes....."</p> <p>3. Review of MetriCide OPA solution testing logs for the surgery department indicated the following: (A) Log #A was listed as endoscopy log and listed an immersion time of five 5) minutes. (B) Log #B was listed as endoscopy log and listed an immersion time of twelve (12) minutes. (C) Log #C was listed as "white bin" and identified by staff as bin used for laryngoscope blades had no immersion time listed and lacked evidence of testing with each use. The log indicated that daily testing was performed.</p> <p>4. Staff member #A1 (Chief Nursing Officer) verified in interview at 1:30 p.m. on 9/22/15 that the MetriCide is checked daily for the laryngoscope blades and not with each use.</p>		<ul style="list-style-type: none"> <li>· Log A in endoscopy is correct that the immersion time is 5 minutes. This log is used for automated disinfection with Metricide OPA Plus. Manufacturer guidelines and the hospital policy on Metricide OPA Plus states an immersion time of 5 minutes for automated high level disinfection in the automatic preprocessor.</li> <li>· Log B in endoscopy is correct that the immersion time is 12 minutes. This log is used for manual high level disinfection with Metricide OPA Plus. Manufacturer guidelines and the hospital policy on Metricide OPA Plus states an immersion time of 12 minutes for manual high level disinfection.</li> <li>· Will have in-service on different types of Metricide and appropriate recommended guidelines for each of them with the staff. (Completed by Nov. 7th)</li> <li>· Nurse manager will do random monthly audits to ensure compliance and report to the Surgery and Anesthesia Committee Meeting on a quarterly basis</li> </ul>		

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S 0610 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(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:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on document review, observation and staff interview, the facility failed to ensure foods were date marked according to policy and failed to clean refrigerator and microwave in 1 of 2 patient nutrition pantry areas.</p>	S 0610	Karen Marker, Dietary Manager, and Nursing are responsible for this plan of correction. All food was removed and disposed of on the day of the survey. Refrigerator and microwave was cleaned immediately. In-service was held on proper cleaning for 1A pantry.	10/08/2015

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	<p>Findings include;</p> <p>1. Facility policy titled "Leftover Food Handling" last reviewed/revised 11/14 states on page 1: "Food leftover that can be used within 3 days needs to be labeled and dated with production date and refrigerator date on the label.....All refrigerator foods that were prepared needs to be used within <b>3 days</b>..... When dating and labeling-everyone must use the letters P, R, and F.....P= preparation date R= Refrigeration date....."</p> <p>2. During tour of the medical surgical unit beginning at 10:45 a.m. on 9/22/15, the following was observed: (A) There was food located in the refrigerator in the patient nutrition pantry including, but not limited to, bowl of pudding and bowl of cottage cheese that had a sticky note with a date on it attached. The date did not indicate if the date was a preparation date or an expiration date. (B) Both the refrigerator for patient snacks and the microwave for use on patient food were soiled.</p> <p>3. Staff member #A1 (Chief Nursing Officer) indicated in interview at 1:30 p.m. on 9/22/15 that the food observed in the nutrition pantry was sent by dietary</p>		<p>New Cleaning schedule is posted in dietary to clean on Mondays and Thursdays as needed. A new sign has been posted on the 1A refrigerator for the associates to follow. Karen will monitor the cleaning schedule and do random checks on the 1A pantry. These results will be reported to the Quality Committee.</p>	

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S 0804 Bldg. 00	<p>and that dietary is responsible for cleaning the refrigerator and microwave.</p> <p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(1) Conduct outcome oriented performance evaluations of its members at least biennially.</p> <p>Based on document review and interview, the medical staff (MS) failed to conduct outcome oriented performance evaluations for 2 allied health (AH) MS members (AH1 and AH2) within the past 2 years for 2 of 2 AH files reviewed.</p> <p>Findings:</p> <p>1. Review of MS Bylaws indicated, in the section titled Ongoing Professional Practice Evaluation, that The MS will use ongoing professional practice evaluation to maintain privileges... The Bylaws were approved by the MS 1/27/15 and by the governing board 2/12/15.</p>	S 0804	Patricia Bowling, Supervisor of HIM and Credentialing, and Rhea Goen, Quality Clinician, are responsible for this plan of corrections. The Ongoing Physician Evaluation spreadsheet will be updated to include all Nurse Practitioners with privileges. Ensure there is data to input on the form by reaching out to the Physician Group (Jodie Sullivan) to obtain data. Work with surgery (Brittney Garloch) to obtain numbers of anesthesia procedures performed by CRNA and Anesthesiologist, performance issues, complaints, etc. This data is monitored quarterly and presented to the Quality and Medical Executive	11/30/2015

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S 0952  Bldg. 00	<p>2. Review of credential files for AH1 and AH2 lacked evidence of a performance evaluation within the past 2 years.</p> <p>3. Review of quality assurance (QA) performance MS evaluations lacked evidence of evaluations for MS members AH1 and AH2.</p> <p>4. On 9/22/15 at 4:30pm, A4, Health Information Manager/MS Services, indicated MS members were evaluated through the quality assurance committee and the evaluations showed on a dashboard QA report. A4 indicated the AH MS members were not included.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6).</p>		Committees, Medical Staff, and the Governing Board. All information will be used at the time of biennial re-appointment of Physicians and Allied Health Members.		

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	<p>Based on document review and interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for two of eight units transfused. (Unit 2a &amp; Unit 7a)</p> <p>Findings include:</p> <p>1. The policy, "Blood Product Administration", last revised 2/2014, read: "When the nurse is ready to transfuse the blood she will go to the lab to retrieve it. At that time the nurse and lab person together will sign it out following the policy. Monitoring the patient: Document vital signs ...15 minutes after infusion is initiated..."</p> <p>2. In review of two patients receiving four blood units, two of these received-units did not have complete documentation, per policy, on the Transfusion Record form including:</p> <p>--Unit 2a, was administered on 9/17/15 at 2:35 p.m.: The unit was issued on 9/17/15 at 2:21 p.m. There was no documentation of the date, time or 'who' transported the unit from the blood bank to the patient.</p>	S 0952	<p>Mia Williams, Manager of IP Services, and Matt Frank, Manager of Lab, are responsible for this plan of correction. All ER, OR and Medical-Surgical Nurses along with lab personnel will be re-trained on blood product documentation and monitoring. Blood audit forms will be updated to include "issued by" and "Transported by". The Emergency room will begin doing blood transfusion audits. All lab personnel will be trained to audit blood records, ensuring timely review. Blood Form Remediation checklists will be given to Unit Managers when an error is found. "Blood Product Administration" Policy was revised to reflect vital sign timing prior to and after transfusion; along with patient monitoring after initiation of transfusion prior to transfer from ER. Nurse Managers will do a "read and sign" with all associates regarding the changes in the policy. Nurse Managers will also do a transfusion review training checklist with each nurse who does transfusions. Lab Manger will do the same with all lab personnel. A Blood audit form will be filled out for each unit transfused. The results will be reported to Unit Manager, who will remediate employees as needed. Audit forms will be updated by Nov. 1st, Education completed by Nov. 1st and audits will be performed on an ongoing basis.</p>	11/01/2015			

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S 1118 Bldg. 00	<p>--Unit 7a, was administered on 8/24/15 at 4:48 a.m.: The 15 minute vitals were documented at 5:00 a.m. which was at 12 minutes (3 minutes early) in lieu at 5:03 a.m. (15 minutes).</p> <p>3. On 9/21/15 at 12:50 p.m., staff member #A15 acknowledged that the two above-listed patient blood units had incorrect or incomplete documentation, per policy.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(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:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the hospital created a condition which may result in a hazard to patients or</p>	S 1118	Sherry Hammond, Manager of Outpatient Services, is responsible for this plan of correction. Laryngoscope was	10/16/2015	

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S 1164 Bldg. 00	<p>employees for one laryngoscope.</p> <p>Findings:</p> <p>1. On 9/22/15 at 11:15am, during facility tour, in the presence of A7, Plant Operations Manager, and S3, Manager/Patient Care Unit, the following was observed in the first patient care room of the cardiac therapy area: On top of the crash cart was a box indicated to contain a laryngoscope handle. Inside the box was a metal laryngoscope handle heavily coated around the neck portion with a white and brownish powdery appearing substance. Whitish powdery residue was also noted inside the box.</p> <p>2. On 9/22/15 at 11:15am S3 inspected the laryngoscope handle, unscrewed the top and slid a battery out of the unit. S3 indicated the unit was "wet". S3 indicated it appeared the batteries had corroded and were leaking out of the unit onto the handle and into the box.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as</p>		immediately removed from department and cleaned according to manufacturing guidelines. Associates re-educated on the crash cart checklist. Manager is to do a monthly walkthrough to spot check compliance. Results will be reported to Quality Committee.		

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	<p>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:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on observation, document review and interview, the hospital failed to maintain evidence of preventive maintenance (PM) on 5 pieces of equipment in 1 rehabilitation unit &amp; 1 radiology unit (a wall pulley, a rebounder, an electric skillet/splint pan, an eyewash station, and a reclining treatment chair).</p> <p>Findings</p> <p>1. On 9/22/15 between 10:30am to 12:00pm and 1:30 to 2:30pm, during facility tour, in the presence of A7, Plant Operations Manager, A16, Marketing Manager, and A17 Clinical Engineering Manager, in the rehabilitation department, the following pieces of equipment were observed: a wall mounted pulley, a trampoline-like rebounder, and an electric skillet; in the radiation department was an eyewash station with the flow spouts turned to the wall, which when tested shot water onto the back wall and the counter (the spouts</p>	S 1164	TriMedx is responsible for this plan of correction. All cited items were added to the TriMedx Hospital inventor list and a PAAR scheduled according to the AEM policy. All items were stickered with a TriMedx sticker. The items will be on a schedule which will be shown on a monthly report that is supplied to Safety. It will then go to the Quality Committee on a quarter basis on up to the Board of Directors. The reclining treatment chair was removed from the department. A new chair is being purchased. The new chair will go through the same process. No new policy needed. Supply Chain will be educated that all equipment that "touches" a patient must be checked in by TriMedx prior to use.	11/01/2015

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	<p>were unable to be moved manually possibly due to what appeared to be whitish heavy mineral deposits); and in the first patient care room of the cardiac therapy area was a reclining treatment chair.</p> <p>2. On 9/22/15 at 10:45am A7 and A17 indicated the wall pulley, the rebounder, and the electric skillet were not included in facility PM.</p> <p>3. On 9/22/15 at 10:45am, S2, Rehabilitation Services, indicated the unit did not perform PM on the pulley, the rebounder, or the electric skillet. S2 indicated the electric skillet is used as a modified splint pan.</p> <p>4. On 9/22/15 at 11:15am, S3, Manager/Patient Care Unit, A7, and A17 indicated the reclining treatment chair came from an outside company and should be maintained for PM by that company. Evidence of PM was requested.</p> <p>5. On 9/22/15 at 1:45pm, A7 indicated the eyewash station in the radiology department was maintained by the maintenance department and agreed to provide documentation of PM.</p> <p>6. Review of PM documentation for</p>				

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S 1172 Bldg. 00	<p>2014/2015 lacked evidence of PM for the wall pulley, the rebounder, the electric skillet, the eyewash station, or the treatment chair and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(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:</p> <p>(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:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on document review and observation, the hospital failed to maintain cleanliness in 3 areas (rehabilitation therapy, CT (computed tomography) room, and sleep lab).</p> <p>Findings:</p>	S 1172	<p>Sleep Lab: Sherry Hammond is responsible for this portion of the action plan. All three wall mounted units were removed from the department on 10/14/15. PT/OT: Kevin Nance is responsible for this</p>	10/30/2015			

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	<p>1. Review of the policy &amp; procedure (P&amp;P) titled Cleaning and Maintenance of Equipment and Facilities, indicated the following: The sleep disorders center should be cleaned routinely. Daily cleaning...Clean and disinfect restroom(s). The P&amp;P was last approved 9/2015.</p> <p>2. On 9/22/15 between 10:30am to 12:00pm and 1:30pm to 2:30pm, during facility tour, the following was observed:</p> <p>a. In the rehabilitation department, in the presence of A7, Plant Operations Manager, and S2, Manager/Rehabilitation Services, in the hand therapy room, next to the hot wax pan, was an electric skillet with a glass type lid inverted inside. The lid was noted to be dust covered with multiple wax-like drippings on the lid and down the side of the skillet; in the physical therapy room was a treadmill with dust noted covering the base.</p> <p>b. In the CT room, in the presence of A7 and S4, Manager/Medical Imaging, it was observed that the top of Medrad injector was coated with heavy dust.</p> <p>c. In the sleep lab, in the presence of A7 and S5, Sleep Lab staff member, in patient sleep room 2, next to the bed, was a wall mounted bedpan unit partially opened, around the outer perimeter of the</p>		<p>portion of the action plan. The electric skillet was moved to a different location so that that it is the only equipment on the cart. That way when patients dip their hands in the paraffin bath, any dripping will land on cart top and be easily cleaned. Completed 10/12/15. All PT/OT associates were educated on the "Cleaning" Policy during a departmental meeting on 10/7/15.</p> <p>Radiology: Joy Brinson is responsible for this portion of the action plan. The department went through a thorough cleaning by Touchpoint during the survey. A department specific "Cleaning" Policy will be created. All Radiology Department associates will be trained on the new policy and procedure. Manager will perform weekly checks to ensure proper cleaning. A checklist will be created to turn into manager to help with awareness of the change and to help create a cleaner environment. Checklist and Policy will be created by 10/30/15.</p>	

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	<p>wall insert was heavy residue of blackish gray dust like globs and the inside of the unit was dust covered.</p> <p>3. On 9/22/15 at 3:30pm, S4 indicated P&amp;P's for cleaning of the facilities are specific to departments, that generally each department is responsible for their own cleaning, and that a specific policy for the CT room was not available, nor was one for general facilities. No further documentation was provided prior to exit.</p>				