

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/09/2012
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NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005075</p> <p>Survey Date: 3-5/9-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>Daeger, Albert Medical Surveyor</p> <p>Nolfi, Sandra, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 03/19/12</p>	S0000		

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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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(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.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 1 offsite service.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for year 2011 indicated they did not include review of reports for the medical records service at the Stress Center offsite.</p> <p>2. On 3-9-12 at 12:55 pm, upon interview, employee #A7 indicated no reports for the above offsite service were reviewed by the governing board in year 2011 and no further documentation was provided prior to exit.</p>	S0270	# 1-2: The Stress Center's Health Information Manager will continue to prepare a monthly 30-day delinquent medical records report for the previous month. This monthly report will now be sent to the St. Vincent Indianapolis Health Information Management Department designee for inclusion in the Quality and Safety Committee and Governing Board's Health Information Management's report. This corrective action plan was finalized on 3-30-2012. Stress Center data will be provided as a separate reporting monitor (page 2 of the monthly report) for the Quality Scorecard starting with the April 2012 Quality and Safety Committee meeting.	03/30/2012			

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</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>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure blood product administration Quality Assurance (QA) audits were conducted per policy for 1 of 3 laboratories that have a blood bank and failed to include monitors and standards for 1 service directly-provided by the hospital and failed to include monitors for 6 directly-provided offsite activities as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. Blood Product Administration Direct Observation Audit last revised 10/15/2009 states, "The following observation checklist was developed</p>	S0406	#1-3: The Blood Bank Director will coordinate monthly Blood Product Administration Direct Observation audits at the North East Blood Bank. Audit records will be processed, monitored, and reported in the same manner as the 86th and Women's Blood Bank. Any identified problem during the audit will be sent to the nursing director of the unit for resolution. Summary reports of the Direct Observation audits are provided to the Blood Bank Medical Director. Monthly audits at NorthEast startet prior to 3-30-2012.#4: The Stress Center's Health Information Manager will continue to prepare a monthly 30-day delinquent medical records report for the previous month. This monthly report will now be sent to the St. Vincent Indianapolis Health Information Management	03/30/2012			

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	<p>referencing the Nursing SOP(s) 'Blood Administration'. Both AABB Standards and CAP requirements were used as guidelines for selection of blood administration audit criteria. Directions: During the administration of a blood product, determine if the SOP is followed. Check 'Yes', 'No', or 'N/A' to indicate compliance with each critical step listed below. Explain all 'No's' in the comment section. All audit conclusion, inform the transfusionist of any noncompliant actions."</p> <p>2. At 9:00 AM on 3/6/2012, staff member D9 indicated the Northeast Lab has not conducted the blood administration audit as defined in the policy. The laboratory has been open since October 2008. The staff member indicated the Northeast Lab usually has only one lab tech in the lab any given day and that makes it impossible for the Northeast lab to do a direct observation audit on staff administering blood to patients in the Emergency Room. Staff could not provide any documentation of the required QA Blood Product Administration Direct Observation Audit.</p> <p>3. At 10:45 AM on 3/7/2012, staff member D12 provided Blood Product Administration Direct Observation Audits for 86th street campus and the women's</p>		<p>Department designee for inclusion in the Quality and Safety Committee and Governing Board's Health Information Management's report. This corrective action plan was finalized on 3-30-2012. Stress Center data will be provided as a separate reporting monitor (page 2 of the monthly report) for the Quality Scorecard starting with the April 2012 Quality and Safety Committee meeting.#5-6: The Director of Clinical and Nursing Quality reviewed and revised the Quality and Safety Committee reporting grid to ensure the presence of all required reporting areas, including those departments not physically located at the Indianapolis campus, on 3-3-2012. The Director of Clinical and Nursing Quality electronically provided an updated grid to all reporting areas and ensured that an electronic meeting notice was sent to the reporting area's responsible persons for their respective scheduled reporting month on 3-30-2012. To ensure ongoing compliance, area presenters will no longer be allowed to skip their assigned reporting month, unless the delay in presentation is validated by the Executive Director of Quality. In this case, the presentation will be moved to the following month. Presenters will receive electronic notification of meeting date 1 month prior to scheduled</p>				

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	<p>hospital. The staff member indicated not having enough staff was not an excuse and it should have been conducted at Northeast Lab. The staff member indicated the audit was to be performed at least quarterly in each of the three labs.</p> <p>4. Review of the facility's QAPI program indicated it did not include any monitors and standards for the directly-provided services of Stress Center medical records,</p> <p>5. Review of the facility's QAPI program indicated it did not include any standards for the directly-provided off-site activities located at Cath and Vascular Lab, St. Vincent Cardiovascular Lab 1st Floor, St. Vincent Hospital Sports Performance, St. Vincent Outpatient Treatment Center (Infusion), St. Vincent Pediatric Center and Transplant Group.</p> <p>6. On 3-9-12 at 10:15 am, upon interview, employee #A7 indicated there was no documentation for the above activities and none was provided prior to exit.</p>		reporting meeting.		

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review, observation, manufacturer's directions and interview, the hospital created 7 conditions which failed to provide a healthful environment that minimized infection exposure and risk to employees and failed to ensure a sanitary environment and prevent contamination of clean linen in various patient care areas.</p> <p>Findings:</p> <p>1. Review of hospital policy MFM.118, entitled Use of Cidex OPA for Vaginal Probe Cleaning, indicated discard Cidex OPA solution after 14 days, even if the test strips indicate a concentration above MEC.</p> <p>2. Review of the Cidex log sheet for Cidex used in the OB-Gyn Clinic section of the St. Vincent Primary Care Center offsite, indicated the Cidex was changed as follows:</p> <p>September 12, 2011</p>	S0554	<p>#1-3: The Primary Care Center Manager reviewed with the OB-GYN Clinical Supervisor the Cidex OPA for Vaginal Probe Cleaning policy on 3-28-12. A new High Level Disinfectant Log was created on 3-20-12 and educated to OB-GYN staff on 3-28-12. This flowsheet allows for documentation of solutions change dates and prompts the next change date. To ensure ongoing compliance of the 14 day solution change, the Clinical Supervisor will verify correct solution change monthly using the established checklist. This checklist is monitored by the Primary Care Center Manager.#4: The uncovered linen cart identified during survey was a temporary cart due to the malfunctioning of the EMS automatic linen dispenser. The linen cart was covered immediately following surveyor identification. This cart was removed on 3-27-11 upon repair of the automatic linen dispenser and there is no longer a linen cart in the hallway. #5-8: The Infection Prevention Department contacted Ms. Ann</p>	03/30/2012	

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	<p>September 28, 2011 (a period of 16 days) November 16, 2011 (a period of 49 days) November 28, 2011 (a period of 12 days) December 16, 2011 (a period of 18 days) January 6, 2012 (a period of 21 days) January 24, 2012 (a period of 18 days) February 23, 2012 (a period of 30 days) February 23, 2012 through March 9, 2012 (0 changes for a period of 15 days)</p> <p>3. Based on the above data, the Cidex was failed to be changed 7 times during the time period September 12, 2011 through March 9, 2012.</p> <p>4. During the tour of the Emergency Department at 12:15 PM on 03/05/12, accompanied by staff members SP4 and SP8, a cart containing clean linen was observed uncovered in an open hallway.</p> <p>5. During the tour of the Pediatric Intensive Care Unit at 2:10 PM on 03/05/12, accompanied by staff members SP11 and SP26, a cart containing clean linen was observed uncovered in the clean utility room.</p> <p>6. During the tour of the 5 South Medical Unit at 9:30 AM on 03/06/12, accompanied by staff members SP9 and SP18, a cart containing clean linen was observed uncovered in a clean room, but other linen and some trash were on the</p>		<p>Hamel on Thursday 3-29-2012 at 1330 to review the current linen storage arrangements utilized in the clinical departments. St.Vincent Indianapolis allows linen carts to be stored with the cart's protective covering open when stored in a clean utility closet with closed doors and segregated space for clean, single use patient care items only. Ms. Hamel voiced agreement to the Infection Preventionist in that the current St.Vincent Indianapolis Hospital process is in keeping with AIA guidelines 2.510.1 "Location of this area within the clean workroom, a separate closet or alcove, or an approved distribution system shall be permitted". On 3-30-2012, the Director of Infection Prevention contacted nursing leadership for the Pediatric Intensive Care Unit, the Acute Neuro Unit, and the Trauma Intensive Care Unit to ensure that the linen closets did not contain any equipment or supplies outside of the single use patient care items and that the supplies were segregated from the linen carts. All closets in these areas were found to be in keeping with AIA guidelines. On 3-20-2012, the Director of Infection Prevention contacted nursing leadership for the 5 South Medical Unit. This closet is also in keeping with AIA guidelines. 5 South Medical Unit leadership stated the linen on the closet floor</p>				

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	<p>floor.</p> <p>7. During the tour of the Acute Neuro Unit at 10:45 AM on 03/06/12, accompanied by staff members SP9 and SP19, a cart containing clean linen was observed uncovered with the protective flaps on top of the cart in a clean room.</p> <p>8. During the tour of the Trauma Intensive Care Unit at 11:25 AM on 03/06/12, accompanied by staff members SP9 and SP20, a cart containing clean linen was observed uncovered with the protective flaps on top of the cart in the clean utility room..</p> <p>9. During the tour of the Digestive Health Unit at 2:20 PM on 03/06/12, accompanied by staff members SP5, SP7, and SP9, a layer of dust was observed on the ledges in the patient care areas.</p> <p>10. During the tour of the Post Anesthesia Care Unit (PACU) at 2:45 PM on 03/06/12, accompanied by staff members SP5, SP6, SP7, and SP9, a layer of dust was observed on the bottoms of the patient carts and along the ledges in the patient care bays.</p> <p>11. During the tour of the main pre-op area at 3:40 PM on 03/06/12, accompanied by staff members SP5, SP7,</p>		<p>was immediately corrected at time of survey on 3-6-12 by placing the linen in the hamper that is located in the closet for linens that accidentally fall to the floor with linen removal from the cart. The trash on the floor was the string that binds the linen in piles on the cart and this trash was immediately disposed of at time of survey on 3-6-2012 in the small trash container intended for the string removal. Placement of dropped linen and line string in the appropriate containers will be reinforced during the 5 South Medical Unit department meetings in April.#9-11: Environmental Services (EVS) correct the dust findings in The Digestive Health Unit, the PACU, and the main pre-op areas on 3-7-12. Correction was validated by the EVS supervisor. To ensure ongoing cleanliness is maintained, the EVS supervisor and each respective area manager validate the condition of the area weekly and document findings on the Environmental Services rounding form.#12: Environmental Services (EVS) immediately corrected the open sharps container found sitting on the Ortho soiled utility room floor on 3-7-12. The soiled sink and dirty ledges, soiled shelves and littered floors were corrected by EVS on 3-8-12. Correction was validated by the EVS Supervisor. To ensure</p>		

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	<p>and SP9, a layer of dust was observed on the bottoms of the patient carts and along the ledges in the patient care bays. A linen cart was observed uncovered in an open area of the room near the patient care bays.</p> <p>12. During the tour of the ortho unit at 10:00 AM on 03/07/12, accompanied by staff members SP10 and SP21, the sink in the soiled utility room was very dirty and the ledges for equipment were soiled with dust and crusty material. An open, used sharps container was sitting on the floor of the room. The shelves holding clean equipment in the clean room were also soiled with dust and dirt and the floor was dirty and littered with scraps of paper.</p> <p>13. During the tour of the ortho pre-op and PACU areas at 11:00 AM on 03/07/12, accompanied by staff members SP10 and SP24, a layer of dust was observed along the ledges in the patient care bays.</p> <p>14. During the tour of the Emergency Department at 12:30 PM on 03/05/12, accompanied by staff members SP4 and SP8, the environmental services staff member working in the area, SP13, was interviewed. He/she indicated the spray bottle used for cleaning the carts and surfaces in the rooms, was filled halfway</p>		<p>ongoing cleanliness is maintained, the EVS supervisor and Ortho manager will validate the condition of the area weekly and document findings on the Environmental Services rounding form.#13: Environmental Services corrected the dust findings in Ortho pre-op and PACU on 3-8-12 in addition to cleaning the entire department. Correction was validated by the EVS Supervisor. To ensure ongoing cleanliness is maintained, the Environmental Services supervisor and Ortho pre-op and PACU manager will validate the condition of the area weekly and document findings on the Environmental Services rounding form.#14-16: Both EVS associates working the ED on 3-5-12 were retrained immediately on chemical identification, dilution rates, and the metering systems. Both EVS associates competency was revalidated on 3-27-12 by their supervisor. All EVS associates will continue to receive job competency review every 6 months. Ongoing competency is validated via direct observation monthly by their assigned EVS supervisor.</p>		

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	<p>with SaniMaster 4 from the automatic dispenser in the closet, then filled the rest of the way with water. When questioned about the length of time the disinfectant needed to remain on the surfaces, staff member SP13 indicated sometimes he/she could barely finish cleaning the room before a patient was put in it.</p> <p>15. Staff member SP14 indicated the automatic dispenser for the SaniMaster 4 was already premixed and should not be diluted. The label on the product directed the disinfectant should be left on for 10 minutes for effective use.</p> <p>16. At 2:30 PM on 03/06/12, the infection prevention staff member, SP7, indicated the clean linen should be kept covered to prevent contamination.</p>			

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S0596	<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 observation, document review and staff interview, the facility failed to ensure the St. Vincent Women's Hospital Cryostat machine was decontaminated as per hospital policy and failed to ensure the St. Vincent Hospital 86th Street cafeteria, coffee cart and Women's Hospital cafeteria met the manufacturer's recommended parts per million active quat concentration for sanitizer used for food-contact surfaces.</p> <p>Findings included:</p> <p>1. The Cryostat Maintenance Policy states, "The purpose of this policy is to ensure performance of appropriate maintenance and function for cryostats in</p>	S0596	#1-3: The Ameripath Quality Assurance Specialist will train the on-site MACL laboratory staff to perform the decontamination procedure for the Cryostat machine to ensure that the machine is decontaminated according to use intervals. The Ameripath Quality Assurance Specialist will be responsible for the ongoing monitoring of the decontamination process and log documentation. This action plan was finalized on 4-2-2012. Training will be completed by 5-1-2012 with full transition of responsibility to on-site MACL laboratory staff immediately following education completion 5-1-2012.#3-6: The Hospital contacted the sanitizer vendor on 3-7-12. The dispenser in the 86th St. kitchen was	04/02/2012			

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	<p>frozen section satellite facilities. Decontamination of the cryostat chamber and microtome is routinely performed using a tuberculocidal agent, Decontamination is performed at specific intervals according to average general usage. Minimal intervals for decontamination are: Weekly - daily usage; Bi-weekly - 5 or less frozen per two weeks; Monthly - 5 or less frozen's per month; Quarterly - 5 or less frozen's per quarter; Bi-annually - 5 or less frozen per 6 months."</p> <p>2. The Frozen Section Log noted the cryostat was used for the following number of cases January and February of 2012: 1/1/2012 through 1/15/2012 - 3 frozen section cases; 1/16/2012 through 1/31/2012 - 12 frozen section cases; 2/1/2012 through 2/15/2012 - 5 frozen section cases; 2/16/2012 through 2/29/2012 - 10 frozen section cases.</p> <p>3. St. Vincent Women's Hospital Pathology cryostat was inspected while touring the Laboratory at 10:00 AM on 3/7/2012. The Frozen Section Room QC log was reviewed for January through March of 2012. The logs revealed the Cryostat was decontaminated on 1/12/2012 and 2/9/2012 with initials by the technician decontaminate of cryostat. The technician initialed remove cryostat</p>		<p>identified as not working properly and was repaired. Dispensing stations located in the 86th coffee cart, and Women's Hospital kitchen were recalibrated. Area associates received retraining on the process for performing quality assurance testing on the sanitizer solution 2 times per day and the process for logging the results. Education was completed on 3-28-12. The Director of Food Services will monitor the logs weekly to ensure ongoing compliance with the quality assurance process.</p>		

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	<p>shavings and wiping out cryostat on other specified days but the decontamination process was evident on the QC logs. At the bottom portion of the QC log states when the cryostat should be decontaminated bi-weekly. However, the QC log noted the cryostat was only decontaminated once a month; therefore, the facility was not decontaminating the St. Vincent Women's Hospital cryostat per policy based on the documentation provided by staff member D12.</p> <p>3. ECOLAB Oasis 146 Multi-Quat Sanitizer states, " Multi-Quat Sanitizer is an effective sanitizer against Eschertchia coli Staphylococcus aureus on food contact surfaces when used at 150 to 400 parts per million active quat."</p> <p>4. At 11:55 AM on 3/5/2012 the 86th street kitchen cafeteria was toured. 3 of 3 red food-contact sanitizing buckets registered less than 100 parts per million (PPM) quaternary ammonia. After further research, the chemical dispensing station was dispensing the chemical for the red buckets less than 100 parts per million. The facility uses OASIS 146 as their chemical for sanitizing food-contact surfaces in the St. Vincent Dietary Department.</p> <p>5. On 3/6/2012 at 10:00 AM, the 86th</p>						

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	<p>street coffee cart was toured. The red container containing Qtat sanitizer 146 for sanitizing food contact areas exceeded 500 parts per million active quat sanitizer.</p> <p>6. On 3/6/2012 at 11:30 AM, St. Vincent Women's Hospital Kitchen was toured. A red sanitizing bucket located in the pizza station that contained Oasis 146 Quat Sanitizer to use on food-contact services registered less than 100 parts per million active Quat sanitizer.</p>			

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S0606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on employee health record review and staff interview, the hospital failed to monitor the immune status of one of four kitchen health care workers reviewed for the five food transmissible diseases to minimize the risk of secondary spread of infection.</p> <p>Findings: 1. On 03/08/12, between 9:30am and 11:30am, employee health record review revealed there was no health record for employee cp# 4 to indicate a history of the five food transmissible diseases had been obtained. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment</p>	S0606	#1-2 The Director of Foods services provided review with all associates about the requirement to report any actual or suspected diseases that are transmissible through food to the person in charge. Each associate signed a document stating the above and the signed form was placed in each associate's file. This review was completed on 3-30-12. To insure ongoing reinforcement of this food borne illness requirement, associates will review and resign a document annually acknowledging understanding with their annual performance review.	03/30/2012			

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	<p>shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), f the food employee or applicant:</p> <p>(1) is diagnosed with an illness due to:</p> <p>(A) Salmonella spp.;</p> <p>(B) Shigella spp.;</p> <p>(C) Shiga toxin-producing Escherichia Coli;</p> <p>(D) Hepatitis A virus; or</p> <p>(E) Norovirus "</p> <p>2. Staff person cp# 8 acknowledged on 03/08/12 between 9:30am and 11:30am that employee cp# 4 had no health records available for review and the immune status for the five food transmissible diseases is unknown.</p>				

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S0608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation, document review and interview, five kitchen staff members failed to wash their hands between removing and changing single-use gloves in the 86th street kitchen cafeteria and failed to follow surgical attire requirements regarding masks in 4 areas (main pre-op and PACU and ortho pre-op and PACU).</p> <p>Findings Included:</p> <p>1. At 11:30 AM on 3/5/2012, five staff members located in the grill station, Sushi Station, and deli station were observed changing their gloves without washing their hands prior putting on the single-use gloves. The staff member's hands were</p>	S0608	#1-3: All dietary associates were retrained on proper hand hygiene and glove use in accordance with 410 IAC 7-24-129. Education was completed 3-30-12. Dietary supervisors will monitor via direct observation and provide remediation as appropriate. In addition, the Director of Foods Service identified 2 associates who will serve as secret shoppers for the dietary areas. Data will be collected in collaboration with Infection Preventionist with results reported to the Hospital's Executive Infection Control Committee on a monthly basis. The Director of Foods Services will revise the hospital's policy Safe Food Handling and Personal Hygiene policy to include 410 IAC 7-24-129 verbiage by 4-6-12.	04/06/2012			

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	<p>observed handling soiled items and wiping counters before the gloves were put on.</p> <p>2. Safe Food Handling and Personal Hygiene Practices Policy Stat ID #99458 states, "To ensure safe food handling practices are followed by Food and Nutrition Services Associates in order to prevent the spread of food-borne illness. Hands must be washed when beginning work and before and after handling contaminated equipment or materials. Gloves are worn on clean hands only."</p> <p>3. Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-129, When to Wash Hands states, "Food employees shall clean their hands and exposed portions of their arms as specified under section 106 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: After touching bare human body parts other than clean hands and clean, exposed portions of arms; After using the toilet room; After caring for or handling service animals or aquatic animals as specified in section 116(b) of this rule; After coughing, sneezing, or using a handkerchief or disposable tissue; After drinking, other than as specified in section</p>		<p>#4-7: This action plan was finalized on 3-27-2012. The Infection Control – Surgery policy will be revised to state "Mask may be appropriately worn by associates and anesthesia during patient transportation to the PACU/phase 2 area for personal protection. Masks must be changed between cases." Surgery Leadership will make these changes in the current policy by 4-23-2012. Ongoing monitoring for compliance will be direct observation by Surgery Managers and Team Leaders with immediate correction addressed for any observed non compliant behaviors. Staff received education of this policy change on 3-28-2012 during department meetings and via email notification. Anesthesia education was completed by the Anesthesia Department Chair on 3-29-2012. During the survey, it was identified that vendors were also observed wearing masks out of the OR. OR Leadership created a memo stating "Surgery's infection control policy states that surgical masks must be removed and discarded when leaving the surgery suite. Failure to follow this policy will result in loss of privileges to enter the surgery department". A copy of this memo was posted at the vendor sign in station as well as in the vendor changing room on 3-29-2012.</p>		

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	<p>113(b) of this rule, using tobacco, or eating; After handling soiled surfaces, equipment, or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with raw food and working with ready-to-eat food; Before touching food or food-contact surfaces; Before placing gloves on hands; and after engaging in other activities that contaminate the hands."</p> <p>4. While touring the main pre-op and PACU (post anesthesia care unit) areas between 1:30 and 3:00 PM on 03/06/12 with staff members SP5, SP6, SP7, and SP9, 6 different staff members were observed coming from the surgical area and returning with surgical masks hanging around their necks.</p> <p>5. While touring the ortho pre-op and PACU areas between 10:45 and 11:30 AM on 03/07/12 with staff members SP10, SP22, and SP24, 4 different staff members were observed coming from the surgical area and returning with surgical masks hanging around their necks.</p> <p>6. The facility policy "Infection Control-Surgery", last reviewed 07/2011, indicated on page 1 under Surgical Attire,</p>				

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	"...1. Surgical masks must be worn, covering nose and mouth completely in the presence of a sterile field. 2. Masks must be changed when they are contaminated. When leaving the OR [Operating Room], masks must be removed and discarded." 7. During the tour of the surgical department at 2:00 PM on 03/06/12, the infection prevention staff member SP7 indicated masks were to be removed when leaving the operating room.				

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S0610	<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 observation and document review, the facility failed to maintain cold holding of 41 degrees F or less or hot holding of 135 degrees F or above for 5 kitchens and failed to ensure raw food was not served to Highly Susceptible Population at 86th street campus and Women's Hospital cafeterias.</p> <p>Findings included:</p>	S0610	#1-2 This finding was corrected immediately 3-5-2012 upon identification by discarding the said food products. Each item is now presented in separate shallow pans to limit the quantity and help ensure temperature maintenance. The cooks check and log food temperature every 4 hours. If any temperature is found outside of range, the cook will immediately notify the	03/27/2012	

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	<p>1. Retail Food Establishment Sanitation Requirements 410 IAC 7-24-287 states, "Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under section 175 of this rule, potentially hazardous food shall be maintained as follows: At one hundred thirty-five (135) degrees Fahrenheit or above; At forty-one (41) degrees Fahrenheit or less."</p> <p>2. At 11:40 AM on 3/5/2012, the 86th Street kitchen cafeteria deli station was toured with the staff member D26. The following items on the cold holding deli serving line were registered at; Roast Beef 49 F; sliced ham 50 F; shaved chicken 50 F; sliced turkey 49 F; and sliced provolone cheese 50 F. The deli slices were observed stacked above the top of the serving line as much as 4 inches which contributed to the deli meat not meeting the required cold holding temperatures.</p> <p>3. At 9:00 AM on 3/6/2012, St. Vincent Hospital Jazzman Kitchen was toured. A ham sandwich in the open front cooler was observed at 48 degrees Fahrenheit.</p> <p>4. At 9:15 AM on 3/6/2012, St. Vincent Hospital Mediterranean Kitchen was toured. A large vegetable pizza and a</p>		<p>supervisor for corrective action instructions. #3 This finding was corrected immediately 3-6-2012 upon identification by discarding the said food products. During survey, the associate was preparing 'made to order' sandwiches. This process was discontinued and only pre-made sandwiches are now served in this area to ensure food temperature consistency. #4 This finding was corrected immediately 3-6-2012 upon identification by discarding the said food products. An additional hot holding cabinet was installed. Pizza temperatures in addition to holding cabinet temperatures are obtained and logged for ongoing monitoring. The Director of Food Services or designee is responsible for reviewing the temperature logs to ensure compliance. #5 This finding was corrected immediately 3-6-2012 upon identification by discarding the said food products. Facilities Services adjusted the cooler temperature. During non peak service hours, the cooler lids are now kept close to assist in temperature maintenance. Food temperature and cooler temperature will be obtained and logged for ongoing monitoring. The Director of Food Services or designee is responsible for reviewing the temperature logs to ensure compliance. #6 This finding was corrected immediately 3-6-2012</p>	
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	<p>personal size sausage pizza were observed hot holding for customer sales and the pizzas registered 129 and 131 degrees F respectively.</p> <p>5. At 9:30 AM on 3/6/2012, St. Vincent Hospital Production Kitchen was toured. The cold area of the tray line registered tuna salad, chicken salad, cottage cheese, potato salad, and slice cheeses at 46, 46, 48, 45, and 46 degrees F respectively.</p> <p>6. At 12:10 PM on 3/6/2012, St. Vincent Women Hospital kitchen/cafeteria was toured. A Milano wrap sandwich was observed at 44 degrees F and a chef salad with assorted meats and cheeses on it registered 45 degrees F.</p> <p>7. Retail Food Establishment Sanitation Requirement 410 IAC 7-24-40 states, "Highly susceptible population means a group of persons who are more likely than other populations to experience foodborne disease because they are: immunoicompromised or adults who are sixty-five (65) years of age or older and in a hospital; preschool age children in a facility that provides custodial care, such as a child care center; or children nine (9) years of age or younger in a school and custodial child care facility that are served juice." Section 410 IAC 7-24-182 states, "A raw animal food, such as raw egg, raw</p>		<p>upon identification by discarding the said food products. Temperature logs were implemented and include actual food sample temperatures in addition to the cooler temperature only.#7-10 All sushi items were removed from the retail cafeteria immediately 3-5-2012 during survey. All sushi items are now labeled by the AFC sushi vendor to clearly state 'no raw fish, seafood, or meat items'. Documentation was also received from all seafood suppliers to validate the fish is fully cooked in accordance with ISDH regulations.</p>				

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	<p>fish, raw-marinated fish, raw molluscan shellfish, or steak tartare or a partially cooked food, such as lightly cooked fish, soft cooked eggs, or rare meat other than whole-muscle, intact beef steaks as specified in subsection (c) may be served or offered for sale in a ready-to-eat form if the food establishment serves a population that is not a highly susceptible population."</p> <p>8. At 12:40 PM on 3/5/2012, the Sushi Station was toured. The Sushi Station prepares several types of packaged sushi product and the prepared sushi packages were also observed in a kiosk located at the other end of the cafeteria. St. Vincent Women's Hospital was also observed serving sushi in a Kiosk on 3/5/2012. The packaged labels located in the Kiosk state, "Contains Raw Fish" and "No Raw Use". The labels that contains raw fish have black writing of type of fish in the packaged product. Both type of packages list the same markings on the labels for the fish used which states, "Fish, Shellfish, Soy". None of the labels indicate the Fish used was fully cooked. The Sushi Station in the 86th street campus cafeteria was observed without any means of cooking the seafood products but do have a cooker to prepare the rice. The walk-in freezer had 2 cases of crabmeat which do not indicate the</p>						

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	<p>crabmeat was fully cooked. Foodservice was waiting on an order; therefore, no other cases were able to be looked at.</p> <p>9. Items prepared at the kitchen cafeteria were listed on Daily Production Report included: Blue Crab Roll; California Roll; Crunchy Cheese Roll; Dragon Roll; Seaside combo; Tempura Roll; Vegetable Roll; Inari; shrimp, etc."</p> <p>10. St. Vincent Hospital contracts Ar1 to provide food service for their hospital. Ar1 contracts a 3rd party vendor who prepares and makes Sushi product for the Dietary Department. The third party vendor who provides the assorted Sushi food has a Standard Sanitation Operating Procedure & Methods Manual. The manual was reviewed and it defines several letters of guarantee that the assorted fish items are delivered frozen and raw. At 3:00 PM on 3/7/2012, staff member D26 indicated the sushi was not cooked on site; however, the rice will be cooked before the assorted food items are prepared.</p>				

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S0732	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based on medical record review, policy and procedure review, and interview, staff failed to accurately document on 2 of 2 patients who left the Emergency Department (ED) without being seen (#N12 and N13).</p> <p>Findings included:</p> <p>1. The medical record for patient #N12 indicated a nursing triage note from 2253 on 03/01/12, a diagnosis of painful urination, and a pain rating of 10 out of 10. Urinary laboratory results from 0119 on 03/02/12 were also in the chart. The emergency record 12B was blank except for "LWBS" written on it. The only other documentation was the "ER Nursing Discharge" form with a discharge date/time of 03/02/12 0200, but the electronic signature of charting was 03/02/12 0331. The disposition was charted as "LWBS-Reason Unknown".</p>	S0732	#1-4 This action plan was finalized on The Emergency Department Director will revise the Left Without Being Seen (LWBS) policy to ensure standardization of policy with the new LWBS form. The new LWBS form will allow the staff to document the following: 1) Patient called X3, 15 minutes apart 2) checking of waiting room and public restrooms if the patient does not respond when name is called for treatment 3) Patient signature for refusal of medical screen prior to leaving or staff signature if patient refuses to sign. The Policy will also be revised to include the necessary documentation for the Electronic Medical Record denoting the disposition of LWBS. Mandatory staff education of policy revision and new form will occur during the April 2012 staff meetings. To monitor form compliance, the Emergency Department Director, or designee, will audit all LWBS forms for 30 days. After 30 days, 10% of all LWBS patient charts	03/30/2012	

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	<p>2. The medical record for patient #N13 indicated a nursing triage note from 2253 on 03/01/12, a diagnosis of penile pain, itching, and a pain rating of 9 out of 10. Urinary laboratory results from 0120 on 03/02/12 were also in the chart. The emergency record 12B was not found in the chart. The only other documentation was the "ER Nursing Discharge" form with a discharge date/time of 03/02/12 0200, but the electronic signature of charting was 03/02/12 0331. The disposition was charted as "LWBS-Reason Unknown".</p> <p>3. The facility policy "Medical Screening and Triage Process" indicated under "A. Initial Assessment", "...If a patient decides to leave the Emergency Department prior to evaluation by a physician, the triage nurse will 'stamp' the patients Emergency Services Record (12-B-1). This 'stamp' stipulates the 'Medical screening offered. Patient refuses at this time.' Nurse will attempt to have patient sign."</p> <p>4. At 1:45 PM on 03/08/12, ED staff members SP4 and SP15 confirmed the lack of charting on medical records N12 and N13. They indicated sometimes patients will leave the ED without staff being aware or being able to ask them to sign the paperwork, but also confirmed the discrepancy of a discharge time of</p>		will be audited on a quarterly basis to ensure ongoing compliance. Policy revision and staff education will be completed by 4-30-12.		

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	0200, but charting at 0331.			

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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(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:</p> <p>(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 nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on medical record review, policy and procedure review, and interview, the facility failed to follow its policy regarding restraints in 3 of 4 patient</p>	S0912	#1-3 The ordering process for initiation and continuation of patient restraint was in transition during week of survey 2-13-12. The hospital now utilizes Computerize Physician Order	04/06/2012			

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	<p>records reviewed who had the application of restraints (#N19, N21 and 3).</p> <p>Findings included:</p> <p>1. The facility policy " Restraint or Seclusion " , indicated on page 6, " ...Restraint order: 1. The initial order for restraint due to non-violent/non-self destructive behavior may be written or obtained by telephone. When the initial order is by telephone, the practitioner must see and examine the patient, and sign the order within 24 hours of initiation of restraint. 2. When restraint is used for non-violent/non-self destructive behavior, the order for restraint must be renewed daily. Prior to the order being renewed, the patient must be assessed by the practitioner, and the practitioner must document that continuation of the restraint is clinical justified. "</p> <p>The policy/procedure indicated the following on page 9; "Restraint or seclusion monitoring requirements: A. 1. At a minimum, the registered nurse will assess the patient in restraint or seclusion upon initiation, every hour and upon release. More frequent assessments are</p>		<p>Entry (CPOE) and eliminates the use of the hand written form cited on 2-12-12. With CPOE, the ordering practitioner will select initial or continuation. All entries are electronically dated and timed. Assessment of patient is documented electronically in the CPOE and includes behavior, least restrictive measures attempted and type of restraint applied. All bedside registered nurses received 16 hours of computerized documentation training which included the process for ordering of restraints prior to the week of 2-13-12 and 24/7 just in time review and reinforcement of the new CPOE process for physician and nursing ended 3-30-12. Daily order for restraints will be audited via computerized reports and monitored by the Nursing Quality Committee on a quarterly basis.#4 The Stress Center Manager modified the hourly checklist completed by the RN to include offering nutrition, hydration, hygiene, and elimination to the patient on initiation, hourly, and upon release. The criteria, 'offering nutrition, hydration, hygiene, and elimination to the patient on initiation, hourly, and upon release', was added to the audit completed at the end of the Violent Restraint or Seclusion episode. Both were completed prior to 4-6-12. Compliance is reviewed by the Stress Center</p>				

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	<p>performed throughout the restraint or seclusion episode if clinically indicated. The assessment must be documented in the medical record and includes the following as needed: Nutrition and hydration Hygiene and elimination"</p> <p>This policy/procedure was last reviewed/revised on 08/2011.</p> <p>2. Review of the electronic medical records throughout the day on 03/08/12 with staff member SP11 indicated the following: The form " Restraint Due to Non-Violent/Non-Self Destructive Behavior " for patient #N19 indicated a new restraint application at 0315 on 12/12/11 by the nurse. The box on the form " Physician/Nurse Practitioner notified of NEW application of restraint " was checked, but the area " Telephone order for restraint received from " was blank and there was no other documentation of whom or when was someone notified. A physician signed the form at 0450 on 12/12/11.</p> <p>The form " Restraint Due to Non-Violent/Non-Self Destructive Behavior " for patient #N21 indicated a</p>		Director/Manager/Clinical Supervisor every month and PRN.				

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	<p>new restraint application, but lacked documentation of a date, time, or signature of nurse assessing the patient and initiating the restraint. The bottom of the form, under " I have examined the patient and have determined the CONTINUED use of restraint is clinically justified " indicated a nurse ' s signature at 0940 on 12/09/11 and a physician ' s signature without a time on 12/09/11.</p> <p>3. At 3:05 PM on 03/08/12, an Intensive Care Unit nurse, staff member SP25, indicated a verbal or telephone order should be written if the nurse initiated the restraints and confirmed the forms were not filled out/signed correctly.</p> <p>4. Review of patient #3's MR indicated the patient was placed in restraint and seclusion on 02-05-12 from 1335 hours to 1700 hours and on 03-04-12 from 2200 hours to 2330 hours and the MR lacked documentation of nutrition, hydration, hygiene and elimination being assessed hourly by a registered nurse.</p>			

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S0952	<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> <p>Based on review of approved medical staff policies and procedures, review of transfusion records, and staff interview, the facility failed to administer one of seven blood transfusions reviewed according to the approved Blood Product Administration (Adult/Pediatric) policy/procedure.</p> <p>Findings included: 1. On 03/07/12 between 10:30 a.m. and 12:00 p.m., review of a policy/procedure labeled: " St. Vincent Indianapolis Hospital, Blood Product Administration (Adult/Pediatric) dated 03/20/11 revealed: "INITIATING THE TRANSFUSION: A. The blood/blood product transfusion must be initiated within 30 minutes from the time the blood was released from the blood bank. MONITORING THE TRANSFUSION: A. The patient must be monitored during</p>	S0952	#1-3: Based on patient location within the hospital system, blood transfusion documentation is completed on either a paper Transfusion Record or in the electronic medical record using the Transfusion Record. Both records are currently audited for completion monthly and reported quarterly to the Transfusion Safety Committee. Audits will be increased to bi monthly beginning 4-16-2012 and the Nursing Quality Committee will also receive audit reports for monitoring. Transfusion Record audits will be conducted by the Transfusion Safety Officer and the Blood Bank Director. Identified incomplete Transfusion Records will be communicated to the appropriate Nursing Leadership with the expectation for document completion following record review for evidence of missing data. If evidence of missing data is not present, Nursing	04/16/2012	

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	<p>the entire transfusion event. Care and observation in addition to the required vital signs (pre-transfusion, 15 minutes into the transfusion, post-transfusion....."</p> <p>2. On 3/7/12 between 10:30 a.m. and 12:00 p.m., review of transfusion record cp# 6 revealed the blood product was released from the blood bank at 1942 and the transfusion was started at 2055 which is 42 minutes over the policy/procedure time. This transfusion also has no post vitals recorded as required by the procedure.</p> <p>3. In interview between 10:30 a.m. and 12:00 p.m., staff person cp# 5 acknowledged transfusion record cp# 6 indicated the transfusion was not initiated according to approved policy/procedure and the post vitals were not recorded as required per approved policy and procedure.</p>		<p>Leadership will document this on the audit and send to the Transfusion Safety Officer. In addition, Nursing Leadership will reinforce the Blood Administration policy with the non compliant associate. Incomplete paper Transfusion Records will be completed within 7 days and the completed record will be scanned into the legal medical record by the HIM department. Electronic medical record Transfusion Records will be completed electronically, provided patient is within 12 hrs post discharge. For discharged patients greater than 12 hrs, the staff member will document the corrected information on a blank medical record form and the form will be sent to HIM for scanning into the patient's legal medical record. Transfusion Record completion goal is 100% compliance. Return of incomplete Transfusion Record or documentation of inability to correct form due to missing data in patient record is 100% compliance. Compliance will be monitored quarterly by the Transfusion Safety Committee and the Nursing Quality Committee. The Transfusion Safety Officer communicated the change in process for the Blood Transfusion audit and correction process to the Nursing Directors 4-3-2012.</p>		

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S1020	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on document review, the hospital failed to ensure the monthly inspection of 1 area where drugs are stored.</p> <p>Findings:</p> <p>1. Review of hospital PolicyStat ID:169535, entitled Inspection of Medication Storage Areas, indicated the Pharmacy or designee will monitor medication stock in all pharmacy areas ... [and] will complete [a] monthly inspection indicating the results.</p> <p>2. Review of a document entitled QUARTERLY OUTDATE DRUG CHECK LIST, for the quarters April, May, June 2011 and July, August, Sept 2011, for the Faculty Practice Clinic section of the St. Vincent Primary Care Center offsite, indicated the reports</p>	S1020	#1-3: All medication stock in the Primary Care Center Pharmacy was inspected to ensure no outdated medications were present. This inspection was completed by Primary Care Pharmacy staff on 3-12-2012. The Director of Ambulatory Pharmacy Services reviewed the Inspection of Medication Storage Areas policy with the Primary Care Pharmacy staff on 3-12-2012. The outdated drug checklist was modified from quarterly to monthly. Beginning with April 2012, monthly inspections of the pharmacy storage areas will begin utilizing the checklist. The monthly checklist will be submitted to and monitored by the Director of Ambulatory Pharmacy Services.	03/12/2012	

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	<p>completed quarterly and not monthly.</p> <p>3. No further documentation was provided prior to exit.</p>			

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S1024	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on observation and document review, the hospital failed to follow its policy regarding medications with expiring or close to expiring dating in 2 instances.</p> <p>Findings:</p> <p>1. Review of hospital PolicyStat ID :169535, entitled Inspection of Medication Storage Areas, indicated all medications with expiring or close to expiring dating will be removed from stock and stored separately in such a manner what it will not be dispensed or administered.</p> <p>2. On 3-7-12 at 10:15 am in the presence</p>	S1024	#1-3: Expired medications in the Faculty Practice and OB-GYN areas of the Primary Care Center were discarded at time of discovery during survey. All medication in the areas were inspected on 3-7-12 by the Primary Care Center Manager to insure no other outdated medications remained. The Primary Care Center utilizes a monthly environmental checklist to ensure ongoing compliance. Medication expiration inspection will be added to this checklist by April 6, 2012.	04/06/2012	

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	<p>of employee #A10, it was observed in Room 110 of the Faculty Practice section of the St. Vincent Primary Care Center offsite, there were 10 bottles of lidocaine with an expiration date of March 1, 2012.</p> <p>3. On 3-7-12 at 10:50 am in the presence of employee #A10, it was observed in the OB-Gyn Clinic section of the St. Vincent Primary Care Center offsite, there was 1 bottle of Ferric Sulfate Aqueous with an expiration date of September 30, 2011.</p>			

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S1118	<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, manufacturer's recommendations and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in four (4) instances Northeast offsite Audiology Department, St. Vincent's Women Hospital's Frozen Section Room, Imaging Department, and Maintenance Department, failed to properly store tube feeding solutions in 4 patient care areas (pediatrics, medical, neuro, and intensive care) and created conditions which resulted in a hazard to patients, public or employees in 7 instances.</p> <p>Findings included:</p> <p>1. The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for</p>	S1118	<p>#1-3: The identified Cidex OPA in the Northeast Audiology suite was disposed of by the Quality Assurance Manager on 3/5/2012 following surveyor's inspection. The Otoscope tip process was changed to single use tips on 3-6-12. The single use tips are to be disposed of after each single patient use. In addition to the quarterly Environment of Care rounds, the audiology suite will be monitored regularly by the Rehab Manager to ensure Cidex OPA is not in use.#4: On 3-30-12, signage was placed above each sink in the Frozen Section Room to identify the sink's designated use. The sink adjacent to the cryostat is the designated work sink and was cleaned by Environmental Services. On 3-30-12, the soap dispenser located at the work sink was moved to the designated handwashing sink (also contains the eye wash station) located at</p>	04/02/2012			

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	<p>semi-critical devices, in the Audiology Department of the Northeast offsite. Cidex OPA manufacture sheet requires use PPE when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns and the lids for the test strips and solution need to be tight fitting.</p> <p>2. At 10:30 AM on 3/6/2012, the Audiology Department of the Northeast offsite was toured. An exam room was observed with a sealed gallon of Cidex OPA in the cabinet. On the counter top was a cover plastic blue container had Cidex OPA within the container. The container lid had a yellow post-it not on it with a date of 3/2 stuck to the lid. The room did not have any goggles, gloves, and fluid resistant gown when handling the high-level disinfectant.</p> <p>3. At 10:45 AM on 3/6/2012, staff member D23 indicated the department went without an Audiologist for awhile; however, the main hospital sent over an Audiologist to work in the department of Thursdays and Fridays right now. The staff member indicated the disinfectant was used for swabs until recently they have purchased single-use ear swabs.</p> <p>4. At 10:30 AM on 3/7/2012, the Frozen Section Room was inspected. The room had two identified hand washing sinks.</p>		<p>the opposite end of the room. On 3-30-12, the paper towel dispenser was rechecked to ensure dispenser was filled with paper towels. Environmental Services staff were informed of the sink designation on 3-30-12 and will maintain responsibility for ensuring hand soap and paper towel stocking. The MACL Laboratory Manager will perform periodic inspection to ensure both sink areas are properly maintained. #5-7: The identified unsecured code cart located at the Women's Hospital Imaging Department was corrected on 3-7-12 following surveyor inspection. Cart inventory was completed to ensure all emergency equipment was present. A secure number tag was placed on the cart following inventory inspection. The Imaging Quality/Risk Consultant reviewed with the Imaging Services Manager the Code 1: Adults, Pediatric, and Neonates and Defibrillation Inspection policy to ensure safe and compliant patient care on 3-30-2012. This action plan was finalized on 3-30-12. Staff will receive reinforcement of policy requirements specific to daily cart inspection and documentation during department meetings scheduled for 4-2/6-2012. The Imaging Services Manager is responsible for conducting periodic checks throughout the month. Emergency equipment</p>				

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	<p>The handwashing sink adjacent to the cryostat machine was observed heavily soiled with debris. The sink also had a heavily soiled green scouring pad and soiled pair of scissors on the back side of the handwashing sink. The hand washing sink located at the opposite end of the room with an eye wash station plumbed into the faucet was missing detergent for a person to wash their hands, The sink did contain paper towels for drying.</p> <p>5. Code 1 Policy: Adults, Pediatrics and Neonates Policy Stat ID #58663 states, "Every department with a code cart will be responsible to perform a daily verification of the following on days in which the department is operational: Code cart supply expiration date; Pharmacy drug expiration date; Code cart lock in tact, not broken;"</p> <p>6. At 10:55 AM on 3/7/2012, the Imaging Department of the Women's Hospital was toured. The department had 2 code carts. The solid red cart was tabled X-ray on the clip board attached to the code cart. The red code cart contained assorted supplies, assorted syringes, IV solution (Sodium Chloride). etc. The code cart was not locked nor had a secure number tag on it. There was no evidence of a tag missing nor evidence of it being logged down as not being tagged. The</p>		<p>checks will be added to the monthly Regulatory Readiness inspection form by 4-30-2012 to ensure ongoing compliance. The Imaging Services Manager is responsible for the monthly inspection completion. #8: The Women's Hospital Boiler Room and 2 electrical rooms citation was corrected on 3-30-12. All debris on floors and all flammable materials located in the electrical rooms were removed. The Manager of Facilities Services is responsible for the correction and ongoing compliance related to this citation. The Manager will inspect these areas at a minimum of monthly to ensure the rooms remain safe and orderly.#9-13: This action plan was finalized on 4-2-2012. The Clinical Nutrition Manager will physically visit each inpatient nursing unit to meet with a member of the unit leadership team to establish which cabinet or other light protected area will be designated for enteral tube feeding storage prior to 4-30-2012. A laminated sign will be posted on the door of the designated area. This sign will serve as communication of enteral tube feeding storage for both the dietary wait staff that deliver the enteral feedings and the nursing staff. The Clinical Nutrition Manager and each nursing leadership team will be responsible for communicating this change with their respective staff by 4-30-2012.#14-16: All</p>				

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	<p>other code cart in the same location contained the same type items and it had a tag in tact on it.</p> <p>7. At 11:00 AM on 3/7/2012, staff member D14 indicated the women's hospital Imaging Department is open 24/7 and the code cart should of been secured. The staff member does not know how the code cart was not secured.</p> <p>8. The St. Vincent Women's Hospital Maintenance Department was toured. The Boiler Room and two electrical rooms were observed with heavy accumulation of loose debris on the floor. One electrical room was observed with cardboard boxes stacked on tope of each other interlocked and blocking electrical panels for easy access and the cardboard posed a fire threat of flammable material obstructing 400 phase electrical boxes.</p> <p>9. During the tour of the 3rd floor pediatric unit at 2:55 PM on 03/05/12, accompanied by staff members SP11 and SP17, 3 bottles of Jevity 1.5 tube feeding were observed on the counter in the well-lit nourishment room.</p> <p>10. During the tour of the 5th floor medical unit at 9:30 AM on 03/06/12, accompanied by staff members SP9 and SP18, 2 bottles of Osmolite tube feeding</p>		<p>identified medical gasses were immediately secured on 3-6-12 upon identification by the surveyor. On 3-9-12, the Manager of Facilities Services reviewed with the staff in the Refrigeration Shop about the safety requirements associated with medical gas tanks and the potential harm associated should the tank head break off the compressed cylinder. In addition to the scheduled Environment of Care inspections, the Manager will inspect these areas at a minimum of monthly to ensure no compressed medical gasses are left unsecured. #17-18: The alcohol-based hand sanitizer identified directly above an electrical outlet outside the Pediatric CT Scan Room was removed and relocated on 3-6-2012. The Manager of Facilities Services re-educated the Area Maintenance associates about the fire safety hazards associated with locating alcohol-based hand sanitizers above electrical outlets and the required distances for mounting. The Manager of Facilities Services will be responsible for ensuring Area Maintenance observe the required distances for mounting during periodic area inspections.</p>		

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	<p>and 1 bottle of Glucerna tube feeding were observed on the counter in the well-lit pantry.</p> <p>11. During the tour of the acute neuro unit at 10:45 AM on 03/06/12, accompanied by staff members SP9 and SP19, 2 bottles of Jevity tube feeding, 1 bottle of Osmolite tube feeding, and 1 bottle of Glucerna tube feeding were observed on the counter in the well-lit pantry.</p> <p>12. During the tour of the trauma ICU at 11:25 AM on 03/06/12, accompanied by staff members SP9 and SP20, 2 bottles of Jevity 1.5 tube feeding were observed on the counter in the well-lit nourishment room.</p> <p>13. The manufacturer's labels on all of the tube feedings indicated the products contained light sensitive nutrients and should be protected from light.</p> <p>14. On 3-6-12 at 10:35 am in the presence of employee #A10, it was observed in the Refrigeration Shop, there were 2 small oxygen tanks on the floor unsecured by chain or holder.</p> <p>15. On 3-6-12 at 11:25 am in the presence of employee #SP9 and SP20, it was observed in a soiled utility room,</p>						

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	<p>there was 1 filled oxygen tank on the floor unsecured by chain or holder.</p> <p>16. If any of the above extinguishers and tanks were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>17. On 3-5-12 at 1:55 pm in the presence of employee #A10, it was observed in the Radiology area outside the Pediatric CT Scan Room, there was an alcohol-based hand sanitizer (ABHS) on the wall directly above an electrical outlet.</p> <p>18. The above location of the ABHS directly over an ignition source posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source.</p>			

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S1150	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.</p> <p>Findings:</p> <p>1. On 3-6-12 at 9:40 am in the presence of employee #A10, it was observed in the soiled utility room in the hydrotherapy area there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S1150	#1: A backflow prevention device was added to the flexible hose connected to a water spigot in the soiled utility room in the hydrotherapy area on 3-27-2012 by the Area Maintenance associate. The Manager of Facilities Services reviewed with the Director of Environmental Services the code requirements for chemical dispensers and portable water connections on 3-27-2012. The Environmental Services Supervisors will be responsible for monitoring the workings of the Environmental Services closets and ensure that Facilities Services is notified of any needed work or repairs.	03/27/2012	

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview the facility failed to ensure that defibrillators be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries be maintained in 2 instances.</p> <p>Findings include:</p> <p>1. Review of the Zoll M Series defibrillator manufacturer recommendations indicated the following on page 9-1; "Periodic Testing The following operational checks should be performed at the beginning of every shift to ensure proper equipment operation and patient safety. (Refer to the appropriate Operator's Shift Checklist at the end of this section)."</p> <p>2. On 03-07-12 at 1000 hours during the tour of the Imaging Department at the St.</p>	S1168	#1-4: St. Vincent Women's Hospital provides imaging services 24/7 and utilizes a variety of shift lengths to ensure safe and effective radiology technologists coverage. The organization has a standardized emergency equipment log that allows for every 12 hr defibrillator checks for those departments open 24 hrs. Departments with emergency defibrillators, but not open 24 hrs, document the check on the day shift line. The Imaging Quality/Risk Consultant reviewed with the Imaging Services Manager the Code 1: Adults, Pediatric, and Neonates and Defibrillation Inspection policies to ensure safe and compliant patient care on 3-30-2012. The Manager immediately implemented every 12 hr defibrillator checks. These checks are now conducted at approximately 0700 and 1900 daily. Staff will receive reinforcement of this immediate change in process during department meetings scheduled for 4-2/6-2012. The Imaging	04/06/2012	

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	<p>Vincent's Women's offsite a Zoll M Series Defibrillator was observed.</p> <p>3. Review of Defibrillator Discharge Log indicated the Zoll M Series Defibrillator was discharged 1 time per day during the month of February 2012.</p> <p>4. On 03-07-12 at 1020 hours staff #51 confirmed that staff work in 10 hour shifts.</p> <p>5. On 03-05-12 at 1410 hours during the tour of the Emergency Department at the Northeast offsite a Zoll AED Plus was observed.</p> <p>6. On 03-05-12 at 1410 hours staff #41 confirmed that there was no discharge log maintained for the Zoll AED Plus.</p>		<p>Services Manager is responsible for conducting periodic checks throughout the month. Emergency equipment checks will be added to the monthly Regulatory Readiness inspection form by 4-30-2012 to ensure ongoing compliance. The Imaging Services Manager is responsible for the monthly inspection completion.#5-6: The AED in the Emergency Department at Northeast offsite was checked by the Security Officer on 3-5-2012 following the surveyor's inspection. The Quality Assurance Manager for the Northeast offsite added the Emergency AED Device check to the Monthly Security Systems Check rounding form on 3-5-2012. The Security Team Lead will be responsible for monitoring and confirmation of log completion during the quarterly Environment of Care rounds.</p>		

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S1186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on observation, policy and procedure review, safety plan review, and interview, the facility failed to follow safe practices regarding infectious waste on the ortho unit.</p> <p>Findings included:</p> <p>1. During the tour of the ortho unit at 10:00 AM on 03/07/12, accompanied by staff members SP10 and SP21, the following observations were made: A. A filled sharps container with an open</p>	S1186	#1-5: All unsecured sharps containers on the nurse server stations outside the orthopedic patient rooms and on the floor of the soiled utility rooms were contained with lids, removed from the orthopedic unit, and delivered to the Medical Waste holding area by trained Environmental Services associates. This work was completed by 1700 on 3-7-2012. The Director of Infection Control discussed this issue with the Ortho Unit Manager and reviewed the correct process for removal of full	03/12/2012			

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	<p>top, sitting on the floor of the soiled utility room.</p> <p>B. Unsecured sharps containers sitting at the nurse servers on the outside of each patient room. There was a circular opening on the top of the containers where the contaminated contents of the box could be dumped out or accessed.</p> <p>2. The facility policy "Infectious Material and Waste", last reviewed 01/2011, indicated, " Policy A. Infectious material and waste must be handled in a manner to ensure the safety of patients, associates, visitors and the community environment and comply with applicable State Law. B. Departments involved in the generation, collection, and disposal of infectious material and waste will have written departmental procedures to ensure safe handling. Department leadership is responsible for ensuring the education and training of applicable associates."</p> <p>3. The facility's Bloodborne Pathogens Plan for 2012 indicated on page 4, "...6. Regulated Waste- Contaminated sharps shall be discarded as soon as possible in containers that are closeable, puncture-resistant, leak proof on sides and bottom and labeled or color-coded as required."</p> <p>4. During the tour of the ortho unit at</p>		<p>sharps containers. Only the vendor representative or trained Environmental Services associates may remove a full sharps container and transport to the Medical Waste holding area for vendor collection. On 3-12-2012, the Executive Director of the Orthopedic Unit confirmed that all unsecured sharps containers were removed and that staff were instructed to utilize the wall mounted sharps containers inside the patient rooms.</p>		

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	<p>10:00 AM on 03/07/12, staff member SP21 indicated the patient rooms all had wall mounted, secured sharps containers, but the ones outside the rooms were for the nurses' use when they were preparing medications. He/she indicated the nurses or housekeepers should place filled boxes in the biohazard room, not the soiled utility room, but he/she was not aware of any caps or lids to close the boxes. He/she also indicated there was no departmental specific procedure for handling those boxes.</p> <p>5. At 3:00 PM on 03/07/12, both the safety officer, staff member SP23, and staff member SP1 indicated they were unaware of the use of the unsecured, open boxes on the ortho unit.</p>			