

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150082	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
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NAME OF PROVIDER OR SUPPLIER DEACONESS HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN 47747
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005074</p> <p>Survey Date: 8-19/22-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Ken Ziegler Medical Surveyor</p> <p>QA: cloughlin 08/30/13</p>	S000000		

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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S000178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation, the hospital failed to conspicuously post the hospital license in an area open to patients and the public in 3 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 8-20-13 at 10:00 am, in the presence of employees #A7, #A10, and #A11, it was observed in the Deaconess Sleep Center offsite, there was no hospital license posted in an area open to patients and the public. 2. On 8-20-13 at 2:25 pm, in the presence of employees #A7, #A10, and #A11, it was observed in the Deaconess Hospital Breast Center offsite, there was no hospital license posted in an area open to patients and the public. 3. On 8-20-13 at 2:40 pm, in the presence of employees #A7, #A10, and #A11, it was observed in the Progressive 	S000178	<p>Deficiency: 0178: Posting of License Corrective Action to be Taken: A copy of the hospital license is to be placed at Progressive Health in DPC 280, at The Sleep Center, and at the Breast Center. (See attached photos.) Prevention of Future Deficiencies: Review offsite listing for ISDH Licensure and ensure all outlying properties under the hospital license and billing have the hospital license prominently displayed. This will be reviewed each year when the hospital's license is renewed. Responsible Parties: Manager of Engineering and Maintenance and Facilities Manager, Engineering and Maintenance. Target Date: 09/05/2013 (Completed)</p>	09/05/2013			

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S000266	<p>Health offsite, there was no hospital license posted in an area open to patients and the public.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(4)</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>(4) Review the bylaws at least triennially.</p> <p>Based on review of documents and interview, the governing board failed to review their bylaws at least triennially, in 1 instance.</p> <p>Findings:</p> <p>1. Review of the governing board by-laws indicated it was last reviewed 5-18-09.</p> <p>2. In interview, on 8-19-13 at 4:20 pm, employee #A1 confirmed the above and there was no further documentation by exit.</p>	S000266	Deficiency: 0266: Governing Board Bylaws Corrective Action to be Taken: The Governance Committee of the Board of Directors reviewed the Bylaws for Deaconess Hospital and Deaconess Health System on August 27, 2013 and approved the Bylaws. This is documented in the minutes. (See attached Minutes, along with the Bylaws as they were approved; with updates recommended as reflected in the attached Minutes.) Prevention of Future Deficiencies: The Governance Committee's Schedule of Reviews (a document listing the sequence of activities for the Committee) has	09/23/2013	

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S000270	<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 activities for 10 directly-provided services and 2 contracted services.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2012,</p>	S000270	<p>added "Review of Bylaws every three years-Due 2016" to the document.Responsible Parties:Chairman of the Governance Committee (Chairman of the Health System) and President/CEO. Target Date: September 9, 2013: Continue to work with legal counsel to review the Bylaws and report back to the Governance Committee. Report to the Board of Directors on September 23, 2013.</p> <p>Deficiency: 0270: Governing Board Review of Quality ActivitiesCorrective Action to be Taken:To review the reports of quality activities for the identified 10 directly provided services during the next Quality Committee of the Board to be held on 9/27/13. Deaconess Hospital Biomed department stores and provides preventive maintenance on 2 audiometers</p>	09/27/2013	

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	<p>indicated they did not include review of reports for the directly-provided services of MRI and ultrasound (both at Main hospital and Gateway offsite hospital), Trauma Center (Main hospital), and for services at the offsites of Deaconess Family Medicine, Doctor's Plaza X-Ray, Deaconess Gateway Gastroenterology, Deaconess Regional Lab and Radiology Services at Mt. Vernon Medical Center (Radiology only), and The Family Practice Center.</p> <p>2. In interview, on 8-22-13 at 12:00 pm, employee #A6 confirmed the above and no further documentation was provided prior to exit.</p> <p>3. Review of the governing board minutes for calendar year 2012, indicated they did not include review of reports for the contracted service of audiology at the Main hospital and Gateway offsite hospital.</p> <p>4. In interview, on 8-22-13 at 1:20 pm, employee #A6 confirmed the above for the contracted service of audiology and no further documentation was provided prior to exit.</p>		<p>for Deaconess Clinic. Deaconess Hospital does not provide Audiology services under our facility license. Prevention of Future Deficiencies: The identified 10 directly provided services will be assigned to the appropriate Quality Improvement employee for quarterly monitoring. (See attached listing of Quality Representatives for each department.) (See attached Quality Indicators for MRI MC, MRI GW, Ultrasound MC, Ultrasound GW, Trauma Center MC, Deaconess Family Medicine, Dr's Plaza Xray, GW Gastroenterology, Deaconess Radiology at Mt. Vernon, Family Practice Center) Report all QAPI results annually to the Quality Committee of the Board along with QI plan review. Responsible Parties: Director, Quality Improvement Target Date: 09/27/2013</p>		

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S000406	<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. Based on document review and interview, the hospital failed to include monitors and standards for 8 directly-provided services and 2 contracted services as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Based on document review and interview, the hospital failed to have an effective comprehensive QAPI in 1 instance.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI</p>	S000406	<p>Deficiency: 0406:QAPICorrective Action to be Taken:To review the reports of quality activities for the identified 10 directly provided services during the next Quality Committee of the Board to be held on 9/27/13. Deaconess Hospital Biomed department stores and provides preventive maintenance on 2 audiometers for Deaconess Clinic. Deaconess Hospital does not provide Audiology services under our facility license.Prevention of Future Deficiencies:The identified 10 directly provided services will be assigned to the appropriate Quality Improvement employee for quarterly monitoring.(See attached listing of Quality</p>	09/30/2013			

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	<p>program indicated it did not include monitors and standards for the directly-provided services of MRI and ultrasound (Main hospital and Gateway offsite hospital), Trauma Center (Main hospital), and for services at the offsites of Deaconess Family Medicine, Doctor's Plaza X-Ray, Deaconess Regional Lab and Radiology Services at Mt. Vernon Medical Center (Radiology only), and The Family Practice Center.</p> <p>2. In interview, on 8-22-13 at 12:00 pm, employee #A6 confirmed the above and no further documentation was provided prior to exit.</p> <p>3. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted service of audiology at the Main hospital and Gateway offsite hospital.</p> <p>4. In interview, on 8-22-13 at 1:20 pm, employee #A6 confirmed the above for the contracted service of audiology and no further documentation was provided prior to exit.</p> <p>5. Review of a document entitled 3800-NCC Specific Data, QA/PI Indicator-Total Falls per 1000 Patient Days, Q2 FY 2012/2013 indicated</p>		<p>Representatives for each department.)(See attached Quality Indicators for MRI MC, MRI GW, Ultrasound MC, Ultrasound GW, Trauma Center MC, Deaconess Family Medicine, Dr's Plaza Xray, GW Gastroenterology, Deaconess Radiology at Mt. Vernon, Family Practice Center)Responsible Parties: Director, Quality ImprovementTarget Date: 9/27/13 Deficiency 0406 QAPI: Falls Corrective Action to be Taken: • Immediate staff memo (attached) of opportunity for improvement around falls, including the present state of unit specific scores for falls with injury per 1000 patient days for staff to read, sign, and return. •Also, a copy of the current falls policy (attached) for staff to read, sign, and return. •Initiate the twice daily Fall Precaution Audit Tool (attached) with all staff, lead by the team lead or charge nurse, taking a time out and assuring that all fall precautions are on and in place for the appropriate patients. Audit tools to be turned in to manager daily. This audit tool includes chart audits and accountability for hourly rounding. •AIDET/hourly rounding review classes for all staff:1. Acknowledge the patient/family member with eye contact and say "Hello".2. Introduce yourself and explain what you do.3. Duration: Tell the patient</p>				

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	<p>between the 1st quarter of fiscal year 11/12 and the 3rd quarter of fiscal year 12/13, a total of 7 quarters, the total falls per 1000 patient days ranged from 4.37 to 12.07.</p> <p>Further review indicated the Goal/Benchmark was 1.20 falls per 1000 patient days per NDNQI and the trendline for the 7 quarter period slope ranged from approximately 8.5 (from the beginning of the time period) to approximately 8.0 (at the end of the time period).</p> <p>Further review indicated the facility was taking some actions to reduced the rate to not exceed the standard.</p> <p>6. The change in slope was a reduction of approximately 5.9% = (8.5 - 8) / 8.5 for 1 3/4 years. The average number of falls/1000 patient days most recently exceeded the standard by almost 6 times = (7.19 / 1.2). Because of the minimal change in slope reduction and the large exceeding of the standard, the steps taken to improve the situation were ineffective.</p> <p>7. In interview, on 8-22-13 at 9:55 am, employee #A6 confirmed the above data of Total Falls per 1000 Patient Days and no further documentation was provided</p>		<p>how long a given wait or activity will take.4. Explain what is happening and why. 5. Thank the patient for choosing us, waiting, or understanding and ask if the patient has any questions. Prevention of Future Deficiencies: •Staff Signatures in individual staff department files that assure that they have received and understood the memo, policy, and ongoing audit of specific staff performance on fall precautions and interventions. •Staff Signatures in individual staff department files that assure that they have received and understood the memo, policy, and ongoing audit of specific staff performance on fall precautions and interventions. •File of Completed Audit Tools •Certification of course completion with signatures in individual staff department files beginning 9/16/2013 Responsible Parties: 3800/3900 Dept. Manager and 3800 Team Leader Target Date:Memo sent out 9/9/2013.All required signatures on file in staff departmental file by 09/30/2013 will be available upon request. Policy sent with memo on 9/9/2013.All required signatures on file in staff departmental file by 09/30/2013 will be available upon request. Audits began on 9/9/2013.Twice daily audits began on 9/9/2013 and will be maintained in a departmental</p>		

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S000554	<p>by exit.</p> <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 observation, the hospital created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to patients.</p> <p>Findings:</p> <p>1. On 8-20-13 at 2:45 pm, in the presence of employees #A7, #A10, and #A11, it was observed in a small storage room in Progressive Health there was biohazardous waste stored in close proximity to clean items such as bandages, cleaners and gloves. This posed the potential for cross-contamination of the items used on patients.</p>	S000554	<p>quality file by 09/30/2013 and will be available upon request. Course offerings to begin week of 9/16/2013 and to run through week of 09/23/2013. All required certifications of completion will be maintained in individual staff departmental files by 9/30/2013 and will be available upon request.</p> <p>Deficiency: 0554: Infection Control (infectious waste stored in same room with clean patient care supplies.(at PHOI-Physical Medicine)Corrective Action to be Taken:The Bio hazardous waste storage receptacle was not in use and was promptly removed from the small storage room by the company handling removal of the waste.Prevention of Future Deficiencies:The Bio hazardous waste storage receptacle was removed from the facility. The facility arranged for increased frequency in pick-up of its Bio hazardous waste from 1 time per month to 2 times per month to ensure that the Bio hazardous storage receptacle previously located in the small storage room would not be neededResponsible</p>	08/22/2013			

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S000596	<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, staff interview, and observation , the facility failed to ensure chemical Cidex was used according to the manufacturer's recommendations for the Radiology Departments located at Deaconess Gateway Hospital and Deaconess Hospital Ultrasound areas, failed to adhere to facility policy in regard to high risk area cleaning for 2 of 2 surgery areas, failed to adhere to facility policy for glucometer cleaning, failed to disinfect cleaning brushes utilized in central</p>	S000596	<p>Parties:Director of Inpatient/Outpatient Therapy Services Target Date: Complete 08/22/2013</p> <p>Deficiency: 0596 a: Infection Control:: Cleaning and Disinfecting: CIDEX: Vaginal transducers are not being rinsed per CIDEX Manufacturer's recommendations.Corrective Action to be Taken:a. 1. We will rinse per CIDEX manufacturer's recommendation until a new comparable product is chosen:Will provide pictures of the new set up.Will purchase egg timers to ensure staff are rinsing one minute each time.2. Obtain the gallon containers or rearrange workflow to keep in one room to be rinsed as required if no other product is chosen. Prevention of Future Deficiencies:</p>	10/15/2013
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	sterile, failed to develop and implement policies for soda dispenser cleaning throughout the facility, and failed to maintain a clean environment for 1 frozen section room. Findings included: 1. Cidex manufacturer spec sheet requires: Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done. 2. At 10:45 AM on 8/20/2013, Deaconess Gateway Hospital staff member D34 indicated the vaginal probes are soaked in CIDEX solution that is contained on the wall as part of PCI ventilated system for 45 minutes. After which, the probe would soak for 2 minutes in the 32 ounce container of the vented hood system containing water. The staff		3. Revised US P&P41 to reflect manufacturer's recommendations. (Attached) 4. Revise competency for Ultrasound Staff. 5. Educate staff regarding updated rinsing instructions and have competency completed on each staff member. 6. Site visit/network for other best practices and evaluate other options to remove CIDEX from Ultrasound. Responsible Parties: Radiology Manager Target Dates: 1. 10/15/2013. 10/15/2013. 09/09/2013. 10/15/135. 10/15/136. 09/13/2013 Deficiency: 0596 b: Infection Control:: Cleaning and Disinfecting: 1. Environmental Services staff not observing required kill time for Clorox Cleanup. 2. Environmental Services staff not consistently following proper hand washing practices for cleaning of C-diff rooms. 3. Housekeeping closets in surgical areas: a. No measuring device to ensure correct amount of Clorox Cleanup is being mixed in water. b. Unlabeled containers of liquid Corrective Action to be Taken: 1. Environmental Services staff will be re-inserviced on the required kill time when using Clorox Clean Up. 2. Environmental Services staff will be re-in serviced on proper hand washing practices for cleaning C-Diff rooms. 3a. Additional measuring cups for measuring		

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	<p>member confirmed the practice is not recommended by the CIDEX manufacturer, The staff member confirmed that CIDEX was also used in surgery and the vaginal probes are submerged into 3 separate containers of water for at least 1 minute. The staff member indicated he/she located the rinse procedure on the Internet and it recommended submerging the probes in distilled water 3 separate times or what the manufacturer recommends. The staff member indicated CIDEX was recommended by the manufacturer.</p> <p>3. At 1:30 PM on 8/21/2013, Deaconess Hospital staff member D29 indicated he/she does not rinse the vaginal in containers of fresh water 3 separate times as required by CIDEX manufacturer.</p>		<p>Clorox Clean Up to ensure the proper dilution when mixing for cleaning and sanitizing were purchased on August 21 and received on August 29.3b. Environmental Services Operations Manager immediately removed the unlabeled containers from the closet and followed up with staff to communicate that all containers must be labeled with appropriate manufacturer's label.Prevention of Future Deficiencies:Proper dilution ratio for using Clorox Clean Up, proper kill time for Clorox Clean Up, and proper hand washing practices will be reiterated to staff at the monthly department meeting. Staff will be required to sign a document acknowledging their understanding of the above practices. This document will be filed in the Environmental Services Department.Additional measuring cups to use for measuring Clorox Clean Up to ensure the proper dilution when mixing for cleaning tasks were purchased on August 21, 2013 and received August 29, 2013. Staff will be advised at the monthly department meeting to promptly notify the Department Manager when more measuring cups are needed. Add monitoring of Housekeeping closets to Safety Ambassador Rounding Tool for the next 2 quarters. Environmental Services staff will be re-in serviced twice a year on proper labeling of</p>		

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			containers. Staff will be required to sign a document acknowledging of the process. The document will be filed in the Environmental Services Department. Add monitoring of Housekeeping closets for proper labeling of chemicals to Safety Ambassador Rounding Tool for the next 2 quarters. Responsible Parties: Environmental Services Managers Target Date: 09/17/13 Deficiency: 0596 c: Glucometer Disinfecting: ISDH Reviewer observed PCT placing glucometer in docking station without cleaning after use. Corrective Action to be Taken: 1. Docking stations labeled to remind staff to clean meter after each use. Stations state "clean meter after each use".2. Clorox wipes placed at each docking station.3. Policy review with staff, including signed acknowledgement of policy. (See attached.)4. Include details of deficiency and action plan in Staff Weekly Update to be released 9/9/13. Prevention of Future Deficiencies: 5. Perform 10 random observations per month to validate cleaning occurs between patients for a minimum of 3 months. Report monthly results to Gateway director Patient Care Services and Accreditation and Regulatory Officer. Responsible Parties: Manager Gateway Neuro ICU/Neuroscience Unit Target Date:1. Complete2.	

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			<p>Complete3. In process4. To be complete 9/9/135.</p> <p>10/01/2013Deficiency: 0596 d: Disinfecting of Scope Brushes per CDC Guidelines. Corrective Action to be Taken:New department policy created to incorporate cleaning and disinfection of brushes after each use. (See attached policy)Prevention of Future Deficiencies:In-Servicing will be conducted with all staff by department educator. A copy of the new policy will also be provided to all staff.(See attachments.)Responsible Parties: Manager, Materiel ManagementTarget Date: CompletedDeficiency: 0596 e: Cleaning/Disinfecting of Soda Dispenser NozzlesCorrective Action to be Taken: Nozzles were cleaned on all nursing units. (See attached monitoring log.) Write Policy and Procedure for cleaning of soda dispenser nozzles. (See attached policy—Cleaning Soda Dispenser Nozzles.)Prevention of Future Deficiencies:Meet with staff to train on Policy and Procedure—Cleaning of Soda Dispenser Nozzles. (See attached staff training sheet.)Responsible Parties: Operations Manager of Dietetics Dept.Target Date: 9/6/2013Deficiency: 0596 f: Frozen Section Room:Cleaning of room One chemical bottle in the frozen section room was not</p>	

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	4. Facility policy #17.1 titled "High Risk Area Cleaning" last reviewed/revised 6/13 states under procedure on page 1:		clearly labeled. Corrective Action to be Taken: Laboratory Safety Policy titled "General Requirements for Personal and Laboratory Safety", section XXII. has been revised to specifically address the cleaning in rooms outside of the main laboratory (ie. Frozen Section room). Surgical gross rooms will be inspected to determine and remove any unlabeled secondary containers. Prevention of Future Deficiencies: Incorporation of policy changes into the Laboratory Safety policy and procedures (see attached revision.) Histology and other applicable lab staff will be trained on this policy addition and training documented. Development and use of a cleaning log (see attached log) Retraining of histology and other applicable lab staff on the proper labeling of all chemicals and solutions in the surgical gross room, with documentation of training. Add monitoring of Surgical Gross Room for cleanliness and proper labeling of chemicals to Safety Ambassador Rounding Tool for the next 2 quarters. Responsible Parties: Coordinator, Anatomic Pathology, Laboratory and Manager, Laboratory Target Date: 9/22/2013	

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	<p>".....Approved Cleaning Solution: Clorox Clean-Up mixed 8 oz. per gallon of water....." The policy includes the operating rooms.</p> <p>5. Facility policy titled "Mosby's Nursing Skills Blood Glucose Monitoring" last approved 3/22/13 states on page 4 under care of equipment: "All meters MUST be cleaned between patients.....Clean the meter with a cloth that has been dampened with a disinfectant wipe (i.e. Clorox bleach wipe)....."</p> <p>6. Label instructions for Clorox Clean-Up indicates the proper dilution is 8 ounces of solution to each gallon of water.</p> <p>7. Document titled "CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008" states on page 86: "Cleaning items (e.g., brushes, cloth) should be disposable or, if they are not disposable, they should be thoroughly cleaned and either high-level disinfected or sterilized after each use....."</p> <p>8. Housekeeper #1 indicated during tour of the Gateway surgery department beginning at 10:05 a.m. on 8/20/13 that he/she uses 48 ounces of Clorox</p>			

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	<p>Clean-Up to 8 gallons of water.</p> <p>9. Educator #1 indicated during tour of the Gateway surgery department beginning at 10:05 a.m. on 8/20/13 that the facility utilizes a Cytology brush for cleaning scopes and the brush is reused until it is no longer effective. The brush is not disinfected or sterilized between cases.</p> <p>10. Staff member #E1 indicated in interview at 4:25 p.m. on 8/21/13 that he/she was unsure if the facility had a policy for cleaning the soda dispensing nozzles and that the nozzles are not removed for cleaning. There was no policy provided at the time of exit.</p> <p>11. During tour of the Neuro ICU beginning at 12:20 p.m. on 8/20/13, a tech was observed performing a glucose test utilizing the glucometer. He/she performed the test and returned the glucometer to the docking station and did not disinfect the meter.</p> <p>12. During tour of unit 2500 at 4:00 p.m. on 8/21/13, it was observed that the soda dispensing nozzle under the cap had a heavy dark substance built up in the holes which could not be rinsed out with water.</p> <p>13. While on the Pulmonary Oncology</p>						

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	<p>Unit at 2:50 PM on 08/19/13, accompanied by staff members #S2, S3, and S8, housekeeping staff member #A10 was observed and interviewed. Staff member #S10 indicated he/she used Clorox Cleanup for mopping and disinfecting surfaces. He/she indicated he/she usually allowed the surfaces to air dry after wiping, but if staff needed beds or rooms quicker, he/she would dry the surfaces with a clean cloth. The label directions on the Clorox Cleanup indicated a 5-minute kill time was necessary for effective disinfection. When questioned regarding any special requirements after cleaning an isolation room for the organism C-difficile, staff member #S10 indicated he/she would always use the alcohol based hand sanitizer and would sometimes also wash his/her hands. Standard of care was to always wash hands after dealing with C-difficile since the spores were not killed by alcohol based hand sanitizer.</p> <p>14. During the tour of the surgical area at 9:50 AM on 08/20/13, accompanied by staff members #S2, S11, and S15, the housekeeping closet was observed with containers of Clorox Cleanup for disinfection with directions to mix eight ounces of chemical with each gallon of water for mopping, but the area lacked</p>						

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	<p>any measuring cup or device. Three plastic spray bottles of fluid, one, yellow in color, and two, clear, were hanging on the cleaning cart. The labels were worn off/illegible with someone's name written on the bottle with marker, so the contents could not be easily identified.</p> <p>15. The laboratory frozen section room on the surgical unit was toured at 10:15 AM on 08/20/13 with staff members #S2, S11, and S15. The room was unoccupied and the log sheets indicated one specimen was processed through the room today. The sink was very dirty with debris and purple coloration in the mesh drain. The white pad where specimens would be handled/processed was soiled and stained. Two bottles of clear fluid were observed on the shelf above the processing area, one was labeled "Alcohol", but the other one had no label.</p> <p>16. At 10:20 AM on 08/20/13, staff member #S15 indicated the lab was responsible for the frozen section room and surgical staff only delivered specimens there.</p> <p>17. The lab manager, staff member #S29 was interviewed at 11:35 AM on 08/22/13 and indicated the chemicals should all be labeled and lab staff was</p>						

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	<p>responsible for most of the cleaning in the frozen section room. He/she indicated housekeeping staff would probably only mop the floor.</p> <p>18. The facility policy "General Requirements for Personal and Laboratory Safety", last reviewed 03/15/13, indicated, "Counter-tops, phones, doorknobs or other items should be cleaned daily with Clorox Wipes. ...When there is a spill of a specimen or when countertops, phones or keyboards become visibly contaminated, they must be cleaned immediately."</p>				

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S000610	<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, document review and interview, the hospital failed to follow its policy of storage of patient food in a refrigerators in 1 instance.</p> <p>Findings:</p> <p>1. On 8-20-13 at 11:15 am in the presence of employees #A7, #A10, and #A11, it was observed in a refrigerator</p>	S000610	<p>Deficiency: 0610: Containers of facility-prepared containers of food with no date markings Corrective Action to be Taken: Review with staff the policy and procedure—Open and Prepared Foods. (See attached P&P.) (See attached staff training sheet.) Prevention of Future Deficiencies: Physical Medicine will be added to the monthly audit of checking Nursing units. (See</p>	09/06/2013			

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	<p>in the Physical Medicine area of Deaconess Main there were 11 small containers of food in clear plastic cups which had no date written on them. In interview, hospital staff indicated these were for patients and prepared by dietary staff.</p> <p>2. Review of a facility policy entitled Dating Procedure Open and Prepared Foods, reviewed Date: February 2012, indicated:</p> <p>Dietetic Employees will be responsible for: Anytime an item is open and/or prepared and put in the refrigerator, write the date and the letter "R" on the item. Also include Prep (P) dates if applicable.</p>		<p>attached monthly audit form.)Responsible Parties: Operations Manager of Dietetics Dept.Target Date: 09/06/2013</p>		

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S000612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on document review and staff interview, the facility failed to ensure that hot water or other effective chemicals were provided at the proper temperature/concentration for an effective means of destroying microorganisms while using the washers for Deaconess Hospital Inc.</p> <p>Findings included:</p> <p>1. Laundry/Linen Department Internal Policy # O.P. 5-2 Infection Control Article II</p>	S000612	<p>Deficiency: 0612: Infection Control, Linen Handling Corrective Action to be Taken: Internal Policy O.P 5-2 will be revised to comply with CDC Guidelines. (See attached P&P.)Prevention of Future Deficiencies: Chemical Field Representative will conduct monthly titrations of wash formulas to verify proper water temperatures. This information will be filed in the Laundry Department.Responsible Parties: Manager of Environmental Services/Patient Transport/Laundry, Infection Control Coordinator and Chemical Field Representative Target Date: 10/10/13</p>	10/10/2013

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	<p>section B (Last approved January 16, 2013) states, "Per CDC guidelines, hot water washing temperatures of 160 degrees will be achieved during all wash cycles. With the assistance of our chemical field representative, proper chemicals will be used to facilitate maximum microbiocidal action."</p> <p>2. CDC guidelines for laundry services in health care facilities states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully</p>				

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	<p>monitored and controlled at a residual of 50-150 ppm during the chlorine bleach cycle."</p> <p>3. The Deaconess Hospital has two types of industrial washers that both can be calibrated for the desired temperatures and the amount of the chemical that will be dispensed during each wash cycle. The Tunnel washers have 14 assorted cycles based on the laundry that will be washed. The Washer/Extractors has 18 different operation cycles based on the linen that are laundered through them. The documentation provided evidenced the Tunnel Washing operation cycles add bleach into their cycles for 8 minutes at 145 degrees Fahrenheit. However, the Washer/Extractors operation in one operation cycle added 12% bleach for 8 minutes at 150 degree Fahrenheit. Between the Tunnel Washers and the Washer/Extractor Washers, 160 degrees Fahrenheit was achieved an average of 8 to</p>						

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	<p>12 minutes through an entire washing cycle of the laundry for the hospitals and the offsite's. There are exceptions to a few operation cycles that 160 degrees Fahrenheit was never achieved. Therefore, it was unclear if the washing of the laundry/Linen for Deaconess Hospital Inc was using effective means of destroying microorganisms.</p> <p>4. At 10:15 on 8/22/2013, staff member D23 indicated he/she was not sure that the operation cycles of both type washers were effectively destroying microorganisms. However, the staff member confirmed the laundry process was not complying with the Infection Control policy of 160 degrees Fahrenheit water temperature through all washing cycles.</p>				

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S001028	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</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>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on observation, document review, and interview, the hospital failed to follow its policy as to who could access a drug storage area within the hospital in 3 instances.</p> <p>Findings:</p> <p>1. Review of hospital policy P & P No. 40-31 indicated only personnel authorized to administer medications will have access to medications. Further review indicated Front Office Coordinator were not listed as authorized to administer medications. Further review indicated Radiologic Technologists may administer agents related to Radiology under the supervision of a physician or per medical staff approved protocol.</p>	S001028	<p>Deficiency: 1028: Pharmaceutical Services: (Location #1) (PHOI, Physical Medicine) a) Security of and authorized access to all drug areas.b) Medications to be stored in locking cabinet stored in unlocked cabinet Corrective Action to be Taken: Location #1: a) The key to the medicine cabinet was immediately moved and is stored in location which only licensed personnel have access to (ie. Physical Therapists' desk). b) The medication cabinet was immediately relocked and training was provided regarding procedures for keeping cabinet locked.Prevention of Future Deficiencies: Location #1:The Director discussed the policy with all supervisors and coordinators and requested that all staff review the pharmacy policy (P & P 40-31) regarding</p>	09/19/2013	

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	<p>(Examples include radiopharmaceuticals, barium products, iodinated contrast media).</p> <p>2. On 8-20-13 at 11:15 am in the presence of employees #A7, #A10, and #A11, it was observed in the Physical Medicine area a staff member accessed medications from a locked cabinet. In interview on that day and time, the staff member was asked their job title and he/she indicated a Front Office Coordinator.</p> <p>3. On 8-20-13 at 2:35 pm, in the presence of employees #A7, #A10, and #A11, it was observed in the offsite Mammography Stereo Room a staff member had access to 17 vials of Lidocaine HCl 1% 1:100,000 units 30 ml/vial. In interview on that day and time, the staff member was asked their job title and he/she indicated an X-Ray Tech.</p> <p>4. In both of the above instances, neither employee had authority to access the medications according to facility policy.</p> <p>5. Review of hospital policy P & P No. 40-31 indicated Non-controlled Substances must be stored within an ADC, locked cabinet, locked cart, or</p>		<p>medication storage. Only licensed personnel have access to the key for the medicine cabinet. Therapists were instructed to re-lock the medicine cabinet after they removed medication and not to leave it unlocked and unattended. See attached Signature Page regarding training provided to supervisors/coordinators. Continued monthly inspections will be conducted by the pharmacy department to ensure that medications are secure. See attached sample monthly inspection report. Responsible Parties: Location #1: Director of Inpatient/Outpatient Therapy Services Target Date: Complete Deficiency: 1028: Pharmaceutical Services: (Location #2, Deaconess Breast Center) Security of and authorized access to all drug areas. Corrective Action to be Taken: Radiologic technologists at the Deaconess Breast Center are licensed with the ARRT and the IN State Department of Health and as per policy 40-31 are able to access medications to perform radiology procedures. (See attached licenses.) Prevention of Future Deficiencies: Staff will be re-educated on policy 40-31 on who is allowed access to medications. (See attached Signature Page.) regarding training provided to staff. Continued monthly inspections will be conducted by</p>				

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S001118	<p>locked drawer.</p> <p>6. On 8-20-13 at 2:50 pm in the presence of employees #A7, #A10, and #A11, it was observed in the Progressive Health area there was a non-controlled medication, dexamethasone, stored in an unlocked cabinet.</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, documentation review and interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of staff are assured in Deaconess Gateway Generator 2 Rooms and failed to ensure a safe environment for patients by following facility policy and manufacturer's</p>	S001118	<p>the pharmacy department to ensure that only licensed personnel have access to drug areas. (See attached Inspection Form.)Responsible Parties: Administrator, Deaconess Breast Center, Director of PharmacyTarget Date: Complete</p> <p>Deficiency: 1118 a: Physical Plant: Eyewash Station Corrective Action to be Taken: Install eyewash station in Deaconess Gateway Hospital Generator Room 2. (See attached invoice.)Prevention of Future Deficiencies: Eyewash has been added to our ongoing maintenance management system (CMMS) on a PM schedule.Responsible Parties: Facilities ManagerTarget Date: CompletedDeficiency: 1118 b:</p>	09/30/2013			

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	<p>recommendations regarding warming fluids and checking emergency supplies/equipment.</p> <p>Findings included</p> <p>1. The CAT Diesel Generator operator manual indicates a warning when handling the batteries of the generators; WARNING: Fire or Explosion Hazard. Batteries Emit Hydrogen gas. When servicing the Batteries, wear protective gloves and eye protection when handling the batteries or battery cables. If battery acid comes in contact with eyes or any other part of a person's body, immediately flush with water for at least 15 minutes.</p> <p>2. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the</p>		<p>Physical Plant: Blanket/Fluid-warming Cabinets in Surg-Trauma-48001. Temp all cabinets was 120 degrees (F)2. One bag lacked plastic overwrap and none of the bags contained any dates when placed in warmer. Corrective Action to be Taken: • Developed Hospital policy utilizing the Surgery Policy J-2 "Warmed IV/Irrigation Solutions" (See PP Blanket IVF Warmers.) effective 2/12 - same manufacturer products used Hospital wide. • Hospital policy now includes: 1. Warmed IV solutions and irrigation solutions that require warming will be warmed and expiration dates will be adjusted in accordance with the manufacturer's recommendations: (Baxter – 14 days max upon placing in warmer. 2. All fluids placed in warming device for storage will be labeled with a sticker listing the adjusted expiration date. 3. Manufacturer recommendations (See Exhibit A.) attached to the Hospital policy for supporting documentation. Documentation consists of "IV solutions of volumes 150 ml can be warmed in their plastic overpouches to temperatures not exceeding 104 degrees (F) and for a period no longer than 14 days". 4. Separate exhibits added to the Hospital policy demonstrating temperature requirements to be logged daily specific to warming blankets and</p>		

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	<p>guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>3. Generator Preventive Maintenance Orders were reviewed for Deaconess Gateway Hospital. The preventive maintenance orders were for their two Diesel Generators. The preventive maintenance orders indicate that the technician would verify the batter connections are tight; battery water level was at the indicator marks; and to examine the batteries for corrosion/cracks/leaks/swelling.</p> <p>4. At 9:44 AM on 8/20/2013, the Energy Center Building was</p>		<p>warming fluids. . (See Exhibits B&D.)5. Verbiage specific to the requirements for blanket warmers added to the policy so staff understand the difference between the two with supportive manufacturer's recommendations. (See Exhibits A & C.) Prevention of Future Deficiencies:• Review, finalize and approve the newly developed hospital policy with appropriate Leadership and staff. • Utilize the current hospital structure currently in place through Administration with appropriate education to new policies. Ensure specific departments affected by this policy understand process. • Unit managers will monitor the departments that utilize this equipment weekly to ensure policy is being followed and logs are completed daily. • Up-to-date Hospital policy will be placed on appropriate equipment for a staff educational resource tool at all times. Responsible Parties: All Nurse Managers, Directors and staff that utilize warmers as part of their practice. Target Date: 9-9-13 Hospital policy drafted sent to Admin. for final approval process. 9-30-13 Hospital policy finalized and appropriate unit education completed. Weekly monitoring by Unit Manager on each appropriate unit continues for compliance and staff re-educated as appropriate Deficiency: 1118 c-g: Crash Cart readinessc. 4800</p>		

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	inspected at Deaconess Gateway Hospital. The two Diesel Generators are located in two concreted cemented vented wall rooms adjacent to each other, Neither Generator room was observed with an eye washing system in case battery acid comes in contact with the technicians that works on the generator batteries weekly. The closest eye wash system was located near the boilers which was at the opposite end of the building and was not in convenient location for the two Generators.		Crash Cartsd. Same Day Surgery Defibrillatore. PACU Peds Cartf. Cardiovascular Care Centerg. Cardiac Cath LabCorrective Action to be Taken:Revision of policies:SSP OP4-7007 Crash Cart, Responsibility For Maintaining Integrity Of (See attachment 1)• SSP will assume responsibility for assessing the bulbs, batteries, and dopplers during their monthly outdate checks. Mosby's Code Management (See attachment 2)• Policy reviewed and process updated. Returned "Checking and maintaining crash carts" section to the electronic version of the policy. This section was omitted in error during the last revision. Pharmacy P&P 3-4 Emergency Drug Boxes (See attachment 4)• Policy reviewed. Only licensed personnel will have access to medications in the emergency drug boxes. Revision of forms:Crash Cart Daily Checklist F-2594 (See attachment 5)• Removed from checklist "On the 1st Monday every month" since this will now be done by SSP staff routinely throughout the month. Pediatric Emergency Supply Cart Daily Checklist F-5164 (see attachment 6)• Removed from checklist "On the 1st Monday every month" since this will now be done by SSP staff routinely throughout the month.Review and Revision of policies and checklists as described above.These Reviews		

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			and Revisions of policies and checklists as described above will apply house-wide. Prevention of Future Deficiencies: Provide face to face education to SSP personnel regarding changes to the crash cart checking process Provide education to nursing staff via Webinservice regarding changes to the crash cart checking process. Pharmacy to educate staff regarding changes to their process of securing the med box with a white numbered lock. • Rounding with Nursing and SSP management to audit the process until hardwired. • Review monthly at Emergency Response Team – each member will be required to audit the crash cart check process with a second co-worker to ensure accuracy. Provide education to nursing staff via Webinservice regarding changes to the crash cart checking process. This education as described above will apply house-wide. Responsible Parties: Manager, Materiel Management; Staff Dev. Specialist; Manager, CVCC; Manager, CVICU Medical; Manager, SDCC, PACU, Pre-Testing and Outpatient Wound Services; Medication Pharmacy Safety Coordinator; SSP Managers & Nurse Managers Emergency Response Team members; Cardiac Cath Lab Manager; Target Date: P&Ps	

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	5. During the tour of the 4800 Surgical Trauma Cardiovascular Unit at 2:00 PM on 08/19/13, accompanied by staff members #S2, S3, and S4, two warming units were observed on the unit containing blankets in the bottom cabinets and bags of intravenous (IV) fluids in the top cabinets. The temperature of all of the cabinets was 120 degrees Fahrenheit (F). One of the bags lacked its plastic overwrap and none of the bags contained any date other than the manufacturer's expiration date.		updated 09/16/2013;Face to face education to be completed by 9/30/2013; Webinservice (see attach. 3) assigned by 09/16/2013;Webinservice completion due date 09/30/2013; Face to face education to be started on 09/16/2013;Face to face education to be completed by 9/30/2013; Task will be assigned at the September, 23, 2013 Emergency Response Team Meeting. From that point forward, it will be a standing monthly report-out. First report-out will take place at the October ERT meeting on October 28th, 2013 with feedback being sent to the unit manager for individual follow-up with staff. Webinservice assigned by 09/16/2013.Webinservice completion due date 09/30/2013.		

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	<p>6. At 2:10 PM on 08/19/13, staff member #S4 indicated the intravenous bags were used relatively quickly, but could remain in the warmer until the manufacturer's expiration date.</p> <p>7. The facility policy "Warmed IV/Irrigation Solutions", effective 2/12, indicated, "All warmed IV solutions and irrigation solutions that require warming will be warmed and expiration dates will be adjusted in accordance with the manufacturer's recommendations. ...3. All fluids placed in a warming device for storage will be labeled with a sticker listing the adjusted expiration date.." Attached to the policy was documentation from Baxter, the fluid manufacturer, dated January 16, 2013, which indicated, "IV solutions of volumes 150 ml [milliliter] can be warmed in their plastic overpouches to temperatures not exceeding 104 degrees F. and for a period no longer than 14 days."</p> <p>8. At 3:30 PM on 08/21/13, staff member #S3 indicated the fluid warming policy was actually a surgical policy, but confirmed there was no other policy regarding the warmers on 4800 and all of the fluids were manufactured by the Baxter company.</p>						

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	<p>9. During the tour of the 4800 Surgical Trauma Cardiovascular Unit at 2:00 PM on 08/19/13, accompanied by staff members #S2, S3, and S4, three crash carts and one pediatric cart, all containing emergency medications and supplies, were observed. The checklists on the carts indicated, "On the first Monday every month- open Crash Cart, check the following, and replace Crash Cart lock. a.) Laryngoscope bulb and batteries function properly- replace as needed. b.) Doppler (bottom drawer) functions properly- replace battery as needed." Review of the checklists for August indicated the locks were not changed on two of the carts and the pediatric cart on the 5th, the first Monday of August.</p> <p>10. During the tour of the Same Day Surgery unit at 9:05 AM on 08/20/13, accompanied by staff members #S2, S3, S11, and S12, the emergency crash cart was observed in a recessed area with the Lifepak defibrillator flashing "Battery Low" and the unit was unplugged. Review of the checklist indicated the unit had been checked for the day and the last step was to plug the Lifepak in and check that the battery charge light was illuminated.</p>			

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	<p>11. During the tour of the Post Anesthesia Care Unit at 9:25 AM on 08/20/13, accompanied by staff members #S2, S3, S11, and S14, the checklists for the pediatric emergency cart indicated the carts had not been opened with new locks on the first Mondays of July or August.</p> <p>12. At 9:50 AM on 08/20/13, staff member #S15 indicated the crash cart was checked the first Monday of each month and a new lock was applied. However, review of the checklist indicated the same lock was on the cart from June 28 through August 9, 2013.</p> <p>13. Review of the checklists for the crash cart on the Cardiovascular Care Center at 1:55 PM on 08/20/13 indicated the cart was not opened and a new lock applied on the first Monday of July and August.</p> <p>14. At 9:10 AM on 08/21/13, staff member #S24 in the cath lab indicated sterile supply personnel opened and checked the crash cart the last day of each month and provided them with a new lock. However, review of the checklist for August indicated the checks were done by a unit staff member on the 5th, the first Monday of August.</p>			

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	<p>15. At 10:05 AM on 08/21/13, staff member #S25, the manager of sterile supply, indicated the crash cart checks were done the last week of the month by a staff member from his/her department, but he/she was unaware of whether the doppler checks were done. He/she provided a log book for all of the units in the facility, but confirmed there were no dates to determine when the checks were done.</p> <p>16. At 11:45 AM on 08/22/13, staff member #S16, a supervisor in sterile supply, indicated the log book represented information about each of the facility's emergency carts with outdates listed. He/she indicated the log book was reviewed each month for items needing to be replaced, but indicated the crash carts were not opened monthly by the sterile supply staff to check the laryngoscope and Doppler.</p>				

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S001150	<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 8-20-13 at 9:45 am in the presence of employee #A7, #A10, and #A11, it was observed in the Respiratory Therapy Process Room at Deaconess Main there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S001150	<p>Deficiency: 1150: Backflow Preventers (one missing in Respiratory Therapy) Corrective Action to be Taken: Install a backflow preventer in the Respiratory Therapy Process Room. Prevention of Future Deficiencies: Backflow Prevention device has been added to our ongoing maintenance management system (CMMS) on a PM. (See attached Invoice.)Responsible Parties: Manager of Engineering and MaintenanceTarget Date: 08/30/13-completed</p>	08/30/2013	

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S001160	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on documentation review and staff interview, the facility failed to ensure polysomnogram (sleep study machine) are scheduled for preventive maintenance.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Comet series EEG/PSG with AS40 Amplifier System User's manual indicates the sleep study machine needs normal periodic checks for unusual wear, cable abrasion, and routine cleaning. At 10:30 AM on 8/22/2013, staff member D32 indicated the sleep study equipment are not on a routine periodic inspection schedule. The Bioengineering 	S001160	<p>Deficiency: 1160: Equipment in good working order and regularly serviced and maintained (one polysomnography machine at the Sleep Center)Corrective Action to be Taken: Check for unusual wear, cable abrasion, routine cleaning on Sleep Study Machine in Sleep Center.Prevention of Future Deficiencies: PM has been added to our CMMS to address the maintenance issues. Sleep Center Dept. P&P was written for machine cleaning and checking for unusual wear and cable abrasion (See attached Engineering and Maintenance PM Order and Sleep Center P&P and Equipment Checklist.)Responsible Parties: Manager of Engineering and Maintenance & Clinical Manager of Sleep CenterTarget Date: 09/16/13</p>	09/16/2013			

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S001164	<p>staff conduct the preventive maintenance on the equipment.</p> <p>3. At 11:00 AM on 8/22/2013, staff member D31 indicated the sleep study equipment are not on any preventive maintenance schedule.</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 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.</p> <p>Based on document review and staff interview, the facility failed to assure preventive maintenance was conducted on Environmental Service's Automatic Scrubbers as recommended by the manufacturer and failed to provide evidence of preventive maintenance (PM) for 1 piece of equipment (hand/shoulder exerciser).</p>	S001164	<p>Deficiency: 1164: Evidence of Preventive Maintenance for: a) 1 Hand/shoulder exerciser b) 1 Nobles Floor Scrubber Corrective Action to be Taken:a) Provide PM on D-485 Arm Bike. b) Nobles Speed Gleam Floor Scrubber: Floor Scrubber to have a quarterly PM to check the drive transaxle motor, the vacuum motor and the brush motor for carbon brush wear...Prevention of Future Deficiencies:a) PM has been added to our CMMS to</p>	09/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150082		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER DEACONESS HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN 47747			
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	<p>Findings included:</p> <p>1. The Nobles Speedgleam floor scrubber's operator manual states, "Quarterly Maintenance: Check the drive transaxle motor, the vacuum motor and the brush motor for carbon brush wear. Replace carbon brushes when worn to a length of 10 mm or less. Contact an Authorized Service Center for machine repairs. For Safety: When servicing machine, all repairs must be performed by a qualified service person."</p> <p>2. Monthly hospital maintenance logs for 2013 were provided by staff member D23. The logs evidenced all the floor scrubbers are serviced every 2 weeks by the vendor for batteries, blades, and cleanliness. The logs did not evidenced that the required quarterly preventive maintenance were performed on the floor scrubbers as recommended by the manufacturer.</p>		<p>address the maintenance issues. (See attached Work Order.)b) Environmental Services will maintain PM records on site as well as at the vendor so documentation can be readily attained. (See attached Env. Svcs. Inspection Records.)Responsible Parties: Manager of Engineering and MaintenanceTarget Date: a) 09/16/13: Eng. & Mtc. PM has been written and scheduled. Completedb) 09/09/13. (Quarterly PM had been in place. Received documentation from vendor (Gem Chemical).</p>				

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	<p>3. At 10:00 AM on 8/22/2013, staff member D15 indicated the vendor services the floor scrubbers every 2 weeks; however, the logs to not detail the quarterly preventive maintenance as required by the manufacturer. The staff member could not provide evidence that the required quarterly preventive maintenance was conducted.</p> <p>4. On 8-20-13 at 2:50 pm, employees #A7, A#10 and A#11 were requested to provide documentation of PM on a hand/shoulder exerciser located at Deaconess Main, asset tag D-0485. No documentation was provided prior to exit.</p>				