STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150100	A. BUILDING _____ B. WING _____	C 09/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION ST VINCENT EVANSVILLE	3700 WASHINGTON AVE EVANSVILLE, IN 47750

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A 000	INITIAL COMMENTS This visit was for investigation of a federal hospital complaint and a focused infection control survey. Complaint Number: IN00334462 Substantiated: Deficiencies related to the allegations are cited. Infection control deficiencies are cited. Survey Dates: 9/8/20 thru 9/9/20 Facility Number: 005089 QA: 9/15/20	A 000		
A 117	PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s): 482.13(a)(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. This STANDARD is not met as evidenced by: Based on document review and interview, the hospital failed to inform patients of patient rights in advance of furnishing or discontinuing patient care for 8 of 10 patients (P1, P3, P5, P6, P7, P8, P10 and P11). Findings include: 1. Review of PolicyStat ID: 4900459, title Patient Rights And Responsibilities, Last Revised: 9/10/2018, indicated the following: All patients of	A 117		

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

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A 117	Continued From page 1 (The Hospital) are informed in writing of their rights and responsibilities. A written copy of the statement of Patient Rights and Responsibilities is given to patients at the point of registration. 2. Review of the MRs of patients P1, P3, P5, P6, P7, P8, P10 and P11 lacked documentation of the patient and/or patient representative having been informed of the patient's rights in advance of furnishing or discontinuing patient care. 3. On 9/9/20, between approximately 3:30 PM and 4:00 PM, A1, Risk Management Manager, verified 8 of 10 MRs reviewed lacked documentation of the patients having been informed of their patient's rights in advance of furnishing or discontinuing patient care.	A 117		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on document review and interview, the hospital failed to ensure the condition of the hospital environment was maintained in a manner that the safety and well-being of patients was assured for 1 of 1 bariatric MRI (magnetic resonance imaging) carts. Findings include: 1. Review of PolicyStat ID: 8265018, Last Revised 7/22/2020, indicated the following: Adverse Event/Event: A happening or occurrence that is not part of the routine care of a particular patient or the routine operation of the	A 701		

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A 701	Continued From page 2	A 701		

healthcare entity.

Safety Event Review Team (SERT): An interdisciplinary team...that meet at regular intervals to review all safety events. Following a thorough investigation that includes the known complication test, the SERT team will discern whether deviations from generally accepted performance standards occurred, assign the final event severity, and determine preventability for each event. In addition, the team is responsible for support and oversight of action plans following a root cause analysis.

Incidents Involving Equipment: If the event involved equipment... items should be preserved and sequestered. Equipment must be tagged and removed from service immediately. Any equipment that has been sequestered and isolated must not be used or put into service until the device has been tested by... Biomed and approval for return to service has been granted by biomed and Risk Management.

2. Review of Events indicated that on 7/23/20 at 11:30 AM, the following event occurred with patient P3: Patient was being transferred back onto the MRI compatible cart from MRI scan table. Radiology Technologist (RT) 1 and RT 2 were on the pulling side of the patient. RT3 was on the pushing side. When pulling patient over to the MRI cart, the cart gave way even though brakes were engaged. Upon realizing unable to stop the cart, RT1 placed knee under the patient to try to break the fall... Patient was observed landing on right shoulder and scratching back right side of head on wheel of cart. Patient was slid out of MRI room and put in Nuclear Medicine, PET (positron emission tomography) room where we could use Hoyer... to transfer to cart.

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A 701	Continued From page 3 Review of Event follow-up lacked documentation of the cart having been tagged and removed from service and lacked documentation of biomed having tested and/or approved the cart to be returned to service. 3. On 9/9/20, between approximately 2:30 PM and 2:45 PM, in the presence of A1, Manager of Risk Management, in the radiology MRI area, in the hall outside of the MRI room was a patient transfer cart with a transfer board lying on top. 4. On 9/9/20, between approximately 2:30 PM and 2:45 PM, A1 indicated the cart outside the MRI room was the only MRI cart the hospital had in inventory, that it was non-ferrous and was a bariatric accommodating cart that could hold up to 600 lbs. On 9/9/20, between approximately 3:45 PM and 4:15 PM, A1 verified that event follow-up lacked documentation of the cart having been removed from service, tested by biomed and/or approved for return to service following the incident and lacked documentation of an action plan.	A 701		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(2) The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings; This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to develop a system to prevent exposure for controlling COVID-19 and infections/communicable diseases in 1 facility.	A 749		

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A 749	Continued From page 4	A 749		

Findings include:

1. On 9/8/20, between approximately 11:00 AM and 1:00 PM, during facility tour in the presence of A2, Infection Preventionist, common practice of storing dirty face shields in a plastic tub next to and touching a like plastic tub used for storing clean face shields was observed. In at least 4 observances, face shields in the dirty labeled container were overflowing and touching face shields in the clean labeled container. Following are the areas in which the above noted practice was observed:

Emergency room: Two plastic tub-like containers, as noted above, were sitting on the workstation counter. Inside the dirty container was a face shield and inside the clean container of which it was touching were face shields and goggles. On the counter, behind the clean and dirty containers, were pamphlets and various work papers which were also likely to become contaminated.

On 6 south (medical/pulmonary and COVID unit): In the area designated as COVID rooms, sitting on the drop down wall mounted charting trays were tubs, as described above, touching without separation. 3/6 set-ups observed had dirty shields overlapping into/onto the clean container/shields.

On the pediatric unit: Plastic tubs as described above and containing face shields were sitting on the drop down wall mounted charting trays with sides touching.

2. On 9/8/20, between approximately 11:00 AM and 1:00 PM, A2 verified the clean and dirty containers were to be used for cleaning of face shields/PPE (personal protective equipment). A2

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A 749	Continued From page 5 also indicated that the clean and dirty equipment should be separated. A2 indicated he/she believed they should be at least 3' apart. A2 acknowledge dirty face shields were touching clean face shield and thereby contaminating the cleaned equipment. On 9/9/20, between approximately 1:45 PM and 2:45 PM, A2 verified that the hospital did not have a policy for separation distance of clean and dirty PPE/supplies, but that clean and dirty should not be able to come in contact with each other.	A 749		