

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150164	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
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NAME OF PROVIDER OR SUPPLIER MONROE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4011 S MONROE MEDICAL PARK BLVD BLOOMINGTON, IN 47403
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 2/18/2014 through 2/20/2014</p> <p>Facility Number: 004287</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>Ken Ziegler Labratorian/Medical Surveyor</p> <p>QA: claughlin 02/27/14</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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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.</p> <p>Based on document review and staff interview, the facility failed to ensure 10 services/processes were communicated to the Quality Council as defined in the hospital's 2013 Performance & Patient Safety Plan and failed to ensure 6 services/processes were being evaluated as part of the comprehensive quality assessment program (QA&I).</p> <p>Findings included:</p> <p>1. Monroe Hospital 2013 Performance & Patient Safety Plan states, "In identifying important</p>	S000406	S 0406Communicating quality monitoring within the service areas of Endoscopy, Intravenous Radiology, Medical Records, Transcription, PICC Line, Renal Dialysis, Bioengineering, Tissue Transplant, Central Processing and Ultrasound have been corrected as of 2/25/2014. Each area will communicate quality monitoring using the current Measure of Performance Report form currently used to report data to Quality Council. The above noted service areas have been educated in using the Measure of Performance Reporting form 3/04/2014. Communicating quality monitoring data from each service occurs monthly within each service and communicated within their meeting minutes. Quarterly each service submits quality data to Quality council using the Measure of	03/04/2014			

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	<p>key functions, evaluating patient care, and establishing the results of new services/processes or redesigning of existing services/processes, the Medical Staff and Hospital will use a systematic and ongoing process composed of communicating the results of the process. Communicate the results of the process to the Board of Directors, Administrative Staff, Medical Staff, and Departments/Services and the Quality Council. The Monroe Hospital Performance and Safety Plan indicates all services/processes with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p> <p>2. Quality Council minutes and data were reviewed with staff member #4 on 2/19/2014 at 12:30 PM. 10 services/processes did not communicate the results of monitoring and evaluating to the Quality Council as outlined in the 2013 Performance Improvement</p>		<p>Performance Reporting form developed at Monroe Hospital. Quality Council submits quarterly to Medical Executive (MEC) and Board of Directors (BOD) Committees the quarterly quality data submitted by the services. Quality Council's meeting minutes reflect the services quality data received. MEC minutes reflect receiving the quality data submitted by Quality Council. Using the Measure of Performance Reporting form enables each service to consistently communicate: monitoring period, quality data monitored, expected goal, actual goal, trending, plan of correction if trends do not meet or exceed the expected goal. Each service Director has been educated 3/04/2014 on the importance and value of communicating quality monitoring. Service directors and supervisors will share monthly quality monitoring of their service during staff meeting and appropriate committee meetings. The meeting minutes will reflect the monitored quality data. Meeting goals and trending will be evaluated ongoing. All trends that do not meet the expected goal will be evaluated and corrected. Corrections will occur at the time goal not met is noted. Goals not met and corrective action will be reported at the monthly service area meeting and quarterly to Quality Council both verbally and using Measure of Performance</p>		

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	<p>& Patient Safety Plan. The 10 services/processes included: Endoscopy, Intravenous Radiology, Medical Records, Transcription, PICC Line, Renal Dialysis, Bioengineering, Tissue Transplant, Central Processing, and Ultrasound.</p> <p>3. At 1:15 PM on 2/19/2014, staff member #4 indicated the department heads conduct their own monitoring as it relates to quality and are not communicating the outcome of their evaluations to Quality Council for their review and approval. The staff member confirmed the hospital plans require each department to communicate their quality control evaluation summaries to the Quality Council. Staff member# 4 indicated each department selects their own indicators to monitor without input from the Quality Council.</p> <p>4. Quality Council minutes and data were reviewed with staff</p>		<p>report. Quality Council quarterly submits service quality data to MEC and BOD Committee. Meeting minutes will note receiving and reviewing Quality Council's quarterly report consisting of service area's collective quality monitoring data trends and outcome. Quality monitoring and Communication of trends and outcomes of contracted services: Biohazard Waste Hauler (Steris), External Laundry Service (UHS), Security, Ultrasound reading service (SIRA) will be communicated to Quality Council using the Measure of Performance Reporting form used by the service areas as of 2/04/2014. Using the Measure of Performance Reporting form enables each service to consistently communicate: monitoring period, quality data monitored, expected goal, actual goal, trending, plan of correction if trends do not meet or exceed the expected goal. Logs reflecting monitored quality data and service outcome for contracted service will be maintained by the service area using the contracted service. Department Directors and Supervisors of the service area will monitor ongoing quality log. All contracted service not meeting expected goal will be assessed. Action to improve contracted goal expectation will be implemented and communicated as described.</p>				

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	<p>member #4 on 2/19/2014 at 12:30 PM. 6 services/processes could not be identified as being monitored through the hospital Quality Performance Program: Biohazard Waste Hauler (Steris contracted service); External Laundry Service (UHS contracted service); internal Laundry Service, Security, Ultrasound; and SIRA Radiology readings contracted service.</p> <p>5. At 1:32 PM on 2/19/2014, staff members #4 and #18 confirmed the 6 services/process were not monitored and evaluated as defined in the 2013 Performance & Patient Safety Plan.</p>		<p>Department Directors and Supervisors have been educated 3/04/2014 in using the Measure of Performance reporting form. Department Directors and Supervisors have been educated 3/04/2014 to include quality monitoring data in staff meetings and appropriate committee meetings. They have been educated to use the Measure of Performance Reporting form when submitting quality monitoring data quarterly to Quality council providing: monitoring period, quality data monitored, expected goal, actual goal, trending, plan of correction if trends do not meet or exceed the expected goal. Quality Council's minutes will include contracted service quality monitoring data. Quarterly, Quality Council will submit all service area and contracted service quality data to both MEC and BOD Committee. MEC and BOD Committee meeting minutes are to reflect receiving and review of Quality Council's report from service areas and contracted services quality monitoring data. Any contracted service not meeting expected goal will be evaluated and action to meet or exceed goal will be implemented by department Director or Supervisor at time of noted trend. Goals not met for the contracted service and corrective action will be reported at the monthly service area meeting and at</p>		

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S000554	<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, documentation review, and staff interview, the facility failed to ensure chemical Cidex OPA was used to soak medical devices for 12 minutes and failed to properly rinse the medical devices as recommended by the manufacturer and failed to ensure a safe environment for patients by ensuring clean supplies and equipment were protected from contamination in patient care areas.</p> <p>Findings included:</p> <p>1. The hospital was using Ortho-phthalaldehyde Solution</p>	S000554	<p>Quality Council meeting both verbally and using the Measure of Performance Reporting form. The implementation process of reporting quality data will be reviewed by MEC on 3/18/2014 and BOD Committee on 3/20/2014.</p> <p>S 0554 Effective 3/07/2014 anesthesia blades are no longer processed in the Decontamination Room using Cidex. Contaminated anesthesia blades are sent to the Decontamination Room after each case along with all instruments used for that case. Anesthesia blades are washed in a germicidal detergent following manufacturer's directions and moved to the wrapping area. Anesthesia blades are put in peel pack. The anesthesia blades are processed in the Sterrad Sterilizer. All other semi-critical devices are processed through the Medivator (model DSD-201) according to manufacturer's recommendation. The OR Staff and Central Processing (CP) Staff have been educated on the change of practice 3/05/2014. In the event that a semi-critical device comes to Peri-Operative Services for cleaning, the CP staff will refer to the policy Cleaning and High Level Disinfection of Semi-Critical Devices IPC 4.10. The Director of Peri-Operative Services is responsible for ensuring and maintaining of appropriate disinfection of Semi-Critical devices used in peri-operative services. The revised policy IPC 4.10 was review with all peri-operative staff on 3/12/2014. 2/21/2014 Radiology department employees were educated to follow Cidex manufacturer's directions for disinfection of semicritical devices. Emphasis was placed on the manufacturer's direction of a minimum 12 minute length of time semi-critical devices are allowed to soak to achieve disinfection and correct rinse procedure. Once the vaginal probe is placed in the Cidex, a timer will be set for 12 minutes soak time. The vaginal probe is then immersed in minimum 2 gallons of clean water. The timer is set for 1 minute allowing the vaginal probe to soak for 1 minute. The rinse soak water is discarded. The rinse soak process is repeated for a total of 3 times using clean water for each 1 minute soak. The policy Cleaning and High Level Disinfection of Semi-Critical Devices IPC 4.10 was reviewed with radiology staff during in-service 3/10/2014. Quality monitoring of high level disinfection of semi-critical devices is done by using the Infection Prevention Rounds Tool. Disinfection soak time and rinse time logs will be maintained monthly in the</p>	03/12/2014			

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	<p>(Cidex OPA), high level disinfectant for semi-critical devices. Cidex OPA manufacturer sheet requires: Manual processing - Immerge device completely, filling all lumens and eliminating air pockets in Cidex OPA solution for a minimum of 12 minutes at 68 degrees F or higher; 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.</p> <p>2. During the tour of the decontamination area at 2:15 PM on 2/18/2014 accompanied by staff member #20, Cidex OPA was observed in a plastic container.</p> <p>3. At 2:25 PM on 2/18/2014, staff member #27 indicated anesthesia blades were soaked in the Cidex OPA for 15 minutes followed by rinsing the blades off with running</p>		<p>Radiology Department. Outcome trends will be communicated quarterly to Quality Council using the Measure of Performance Reporting form. At such time the expected outcome is not being met, corrective action will be taken immediately to improve the outcome. All actions of correction are communicated to Quality Council using the Measure of Performance Reporting form. The Radiology Department is responsible to educate current and new employees hired in Radiology Department the correct disinfection procedure when using Cidex following the manufacturer's directions for use. All corrugated card board boxes have been removed from the clean supply areas in Medical-Surgical Unit, Intensive Care Unit and Emergency Department. Corrective action was initiated 2/20/2014 and completed 3/05/2014. Staff were educated 2/20/2014 not to store clean supplies with items that have potential risk for cross contamination such as outside shipping containers. Material management stock the clean supply areas. Material Management will monitor clean supply areas to ensure items having potential risk for cross contamination are not in the clean supply area. The Manager of Materials is responsible to maintain only clean supplies are stored in clean areas.</p>				

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	<p>water for 2 to 3 minutes.</p> <p>4. At 11:15 AM on 2/19/2014, the Ultrasound room in the Imaging Department was inspected. Cidex OPA solution was in a container located on the wall with an open container stored in the cabinet of the room.</p> <p>5. At 11:20 AM on 2/19/2014, staff member #47 indicated the vaginal probes of the ultrasound machine soak in the Cidex OPA for 15 minutes then followed by rinsing the probe off in running water in the restroom for 5 minutes.</p> <p>6. During the tour of the Medical-Surgical Unit at 3:00 PM on 02/18/14, accompanied by staff members A2 and A10, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies in the clean storage room and in the medication room.</p> <p>7. During the tour of the Intensive Care Unit at 3:30 PM on 02/18/14,</p>						

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	<p>accompanied by staff members A2 and A10, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies in the medication room.</p> <p>8. During the tour of the Emergency Department at 8:55 AM on 02/19/14, accompanied by staff member A10, cardboard shipping boxes were observed stored on shelves alongside open, clean supplies and IV (intravenous) bags in the clean supply room.</p> <p>9. At 9:00 AM on 02/19/14, staff member A10 confirmed the risk of cross-contamination to clean supplies from the outside shipping containers.</p>			

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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 observation, policy and procedure review, manufacturer's directions, and interview, the infection control committee failed to ensure the surgical department areas were cleaned and disinfected according to acceptable standards of practice.</p> <p>Findings included:</p> <p>1. During the tour of the pre-operative area at 1:00 PM on 02/18/14, accompanied by staff member A20, three individual rooms that were designated as clean and ready for patients, were observed with full trash cans, one of which was overflowing onto the floor.</p>	S000596	<p>S 0596</p> <p>Effective 2/18/2014 all peri-operative staff have been educated to empty trash cans as part of the pre-op room housekeeping between patients. The policy Housekeeping in Peri-operative Services was reviewed with all peri-operative staff 3/12/2014 during staff in-service. All peri-operative staff are expected to assess the appearance of the pre-op room prior to bringing a patient to the pre-op room. Walking rounds are done throughout the day. The Director or Peri-operative Services is responsible to maintain a clean environment in pre-op.</p> <p>Effective 2/18/2014 all peri-operative staff were educated to follow the manufacturer's guidelines for use of chemical 456 cleaning product. Staff were educated chemical 456 is at appropriate concentration following manufacturer's guidelines when obtained from the wall dispenser therefore not needing further dilution. The policy Housekeeping in Peri-operative Services was reviewed with peri-operative housekeeping staff on 3/12/2014 during staff in-service. Using chemical 456 following manufacturer's guidelines has been added to the new employee orientation checklist for employees hired into peri-operative department. The Director of Peri-operative Services is responsible to maintain appropriate use of chemical 456 by all peri-operative staff.</p> <p>Effective 2/18/2014 all peri-operative staff employees were educated to wipe all flat surfaces including wall ledges and wallmounted suction canisters with Sani-wipes as part of the morning cleaning when opening PACU. The policy Housekeeping in Perioperative Services was reviewed with all peri-operative staff 3/12/2014 during staff in-service.</p>	03/12/2014			

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	<p>2. At 1:10 PM on 02/18/14, staff member A24 confirmed the rooms were clean and ready for patient use.</p> <p>3. During the tour of the operative area at 1:30 PM on 02/18/14, accompanied by staff member A20, a bucket of solution for mopping the Operating Suites and a container of solution with rags for cleaning were observed in the area for staff use.</p> <p>4. At 1:40 PM on 02/18/14, staff member A22 indicated the chemical 456 was obtained for cleaning from the automatic dispenser in the housekeeping closet. He/she indicated the chemical was mixed to the proper concentration and that was what was used with the rags for surface cleaning, but he/she put half water and half chemical solution in the mop bucket to prevent streaking.</p> <p>5. Review of manufacturer's directions with the chemical 456 failed to indicated any instructions to dilute the chemical from the automated dispensing station for mopping purposes.</p> <p>6. The facility policy "Housekeeping Procedures", last revised 01/2011, indicated, "Environmental Services and/or Peri-Operative Services Personnel: Damp dust all flat surfaces</p>		Walking rounds are done throughout the day. The Director of Peri-operative Services is responsible to ensure a clean environment in PACU.		

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S000606	<p>and overhead lights every morning prior to the first surgical procedure. Use a germicide-dampened cloth. ...The floor is cleaned with approved detergent germicide and a clean mop head."</p> <p>7. During the tour of the Post Anesthesia Care Unit (PACU) at 2:00 PM on 02/18/14, accompanied by staff member A20, the periphery of the area, wall ledges and wall-mounted suction canisters, were observed soiled with a heavy layer of dust.</p> <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 document review and</p>	S000606	S0606 2/20/2014 staff members noted in the deficiency were	03/31/2014

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	<p>staff interview, the facility failed to ensure 2 of 2 healthcare workers (Environmental Services) who may come in contact with a patient were offered Hepatitis-B vaccination (#13 and #49).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Hepatitis Vaccine Plan policy IPC 5.9 (Last revised April 16th, 2012) states, "All team members with potential for occupational exposure to blood and body fluid will be offered the Hepatitis B vaccination series." The policy references US Department of Health & Human Services Centers for Disease Control and Prevention. Center for Disease Control (CDC) recommends that all healthcare workers be offered Hepatitis-B vaccination series; if employee does not want the series, a declination of such action must be signed by the employee and 		<p>educated on the Hepatitis B Vaccination Plan IPC 5.9. All employee health records are being reviewed for verification of Hepatitis B vaccination or signed declination statement. Employees whose records do not verify Hepatitis B vaccination or signed declination will be contacted by 3/31/2014 offering the choice to receive Hepatitis B vaccine or to sign declination statement. IPC 5.9 policy has been revised to clarify: verification the employee received Hepatitis B Vaccine or signed declination statement is placed in the employee health file and all new employees will be offered the Hepatitis B series. Employee Health will discuss all immunization information with the employee and new hires. Employee Health will provide the Hepatitis B vaccination series. Employee Health will complete the appropriate documentation. Employee Health will review employee health file ongoing for completeness The revised IPC 5.9 policy will be presented to MEC for review at their meeting 3/18/2014.</p>	

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	<p>maintained by the healthcare facility.</p> <p>3. Review of staff member #13's healthcare file indicated the Hepatitis B was documented as not required for the health care worker. The staff member's file did not have evidence of a Hepatitis B refusal declination as part of the health care file.</p> <p>4. Review of staff member #49's healthcare file indicated the Hepatitis B was documented as not required for the health care worker. The staff member's file did not have evidence of a Hepatitis B refusal declination as part of the health care file.</p> <p>5. At 10:15 AM on 2/20/2014, staff member #29 indicated the hospital follows OSHA guidelines as it relates to their staff. However, the staff member did not realize there were exceptions to the rule as it relates to healthcare workers in a hospital. The staff</p>				

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S000612	<p>member confirmed that Environmental Services staff employees are not required to either have the Hepatitis B series or sign a refusal declination.</p> <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.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure the Environmental Service Housekeeping Department was utilizing a chemical detergent registered with EPA for use as a hospital disinfectant or another effective means for properly disinfecting laundry that was used</p>	S000612	<p>S 0612</p> <p>To correct not meeting the CDC guidelines for in-hospital laundry service, on 3/05/2014 the decision was made to terminate all patient care laundry and use the current contract laundry service for all washing of patient care laundry including housekeeping mops and rags in laundry sent to the contracted laundry service. Quality monitoring of trends and outcomes for the contracted laundry service will be communicated in monthly staff meetings and communicated quarterly to Quality Council using the Measure of Performance Reporting form. The Director of Support Services is responsible to ensure no patient care laundry service is permitted within the hospital.</p>	03/05/2014

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	<p>in patient rooms.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. 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 monitored and controlled at a residual of 50-150 ppm during the chlorine bleach cycle." 2. At 12:30 PM on 2.19.2014, the Housekeeping Department was toured. The room had a 			
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	<p>washer/dryer combo. The washer had no attachment connected to it to add hot water to the washing cycles. Located above the washer/dryer combo was a cabinet that had 2 -2 1/2 gallons of 'Member's Mark' detergent. The manufacturer's label on the container did not identify that the product has any disinfecting properties for using on patient care items.</p> <p>3. Member's Mark Laundry Detergent directions for use does not specify how to use the product in the washing machine for properly disinfecting the patient's clothes. Member's Mark chemical detergent was not registered with EPA for use as a hospital disinfectant.</p> <p>4. The washer user instructions indicate to measure and pour into the washer: Add powder or liquid color safe bleach. The washer user instructions specify bleach to be used for disinfectant.</p>			

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	<p>5. At 12:40 PM on 2/19/2014, staff member #8 indicated only 120 degree Fahrenheit water is pumped into the housekeeping washer. Staff indicated the washer was for mops and rags that are used in patient rooms and other patient care units. The staff member confirmed the liquid detergent the staff is using does not specify that it was for a health care setting. The staff member indicated he/she does not know the hot temperature the dryer meets. The staff member indicated the washer and dryer are not being monitored or evaluated regarding meeting the CDC guidelines for washing patient care laundry in a healthcare setting.</p>			

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S000804	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(1) Conduct outcome oriented performance evaluations of its members at least biennially.</p> <p>Based on document review and staff interview, the Medical Staff failed to conduct outcome oriented performance evaluations on 2 of 2 physicians: #30 and #31.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Bylaws of the Medical Staff of Monroe Hospital (Last revised August 15, 2013) Article II indicates Medical Staff members must participate in any type of competency evaluation. Physician staff member #30 was appointed to the medical staff 	S000804	<p>S 804</p> <p>As of 2/18/2014 a checklist noting criteria for medical staff reappointment has been included in the medical staff reappointment process. The written physician performance and competency evaluation has been added to the checklist. The evaluation form is attached to the checklist. The checklist ensures all documentation has been received and present for a physician seeking medical staff reappointment. The checklist and attached documentation is reviewed by Medical Executive Committee (MEC) and Board of Directors (BOD) Committee. MEC and BOD minutes will reflect medical staff reappointment. The last quarterly quality report shows information by physician that was submitted to MEC 2/25/2014 and last quarterly quality report to BOD 3/03/2014. The medical staff reappointment process is identified in the Bylaws of the Medical Staff of Monroe Hospital and Rules and Regulations of the Medical Staff of Monroe Hospital. Policy Ongoing Professional Practice Evaluation MS 1.3 (OPPE) indicates physician performance and competency evaluation criteria. MEC will not consider medical staff reappointment without completed physician performance review. The MEC through the Medical Staff Office is responsible for review of reappointment application and medical staff reappointment.</p>	03/03/2014	

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	<p>in October 2006 and the staff member's credential files did not evidence any performance evaluation.</p> <p>3. Physician staff member #31 was appointed to the medical staff in 2011 and the staff member's credential files did not evidence any performance evaluation.</p> <p>4. At 10:30 AM on 2/18/2014, staff member #11 indicated that none of the credentialed medical staff members have an individual outcome oriented performance evaluation. The staff member indicated that Joint Commission the previous year had concerns that the physicians did not have any performance evaluations to use as a criteria on reappointing to the Medical Staff.</p> <p>5. At 11:15 AM on 2/20/2014, staff member #4 confirmed the hospital was previously cited by the Indiana State Department of Health in 2012 on failing to</p>			

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S001118	<p>conduct performance evaluations on hospital medical staff members.</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, policy and procedure review, manufacturer's directions, and interview, the facility failed to ensure a safe environment for patients by following manufacturer's recommendations regarding warming fluids and ultrasound gel.</p> <p>Findings included:</p> <p>1. During the tour of the surgical department at 1:00 PM on 02/18/14, accompanied by staff member A20, warming cabinets were observed in the substerile areas between the operating suites. The top chambers of the cabinets</p>	S001118	S 1118 Action to correct patient safety and well being within the hospital environment occurred 2/18/2014 by removing fluids and ultrasound gel from the ED warming cabinet. The ED warming cabinet will only contain bath blankets. The Warming Cabinets policy has been revised 3/06/2014. All warming cabinets having bath blankets in single compartment or bottom of double compartment must not exceed temperature 130 degrees F following manufacturer's recommendation. ED staff and peri- operative staff will be educated on the revised Warming Cabinet policy's safe use of contents in the warming cabinet 3/12/2014. Double compartment warming cabinets are in the peri-operative area. The top compartment of double warming cabinet must not exceed 104 degrees F following manufacturer's recommendation for fluids. On 3/10/2014 instruction labels have been applied to both single and double compartment warming cabinets instructing not to change the temperature and the maximum temperature for the respective warming cabinet. The peri-operative Patient Care Tech will fill the warmers in the peri-operative area. Per manufacturer's recommendation Baxter IV solution in their outer pouch can be stored in a warming cabinet for 14 days at 104 degrees F then must be discarded. Per manufacturer's recommendation Baxter solutions (Norman Saline/Sterile water) can be stored in a warming cabinet for 60 days at 104 degrees F then must be discarded. The Patient Care Tech will fill the upper compartment of the warmers and mark the date	03/12/2014	

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	<p>contained bags of intravenous solutions and bottles of irrigation fluids and the bottom chambers contained blankets. The displays indicated the top chamber was 104 degrees F. (Fahrenheit) and the bottom chamber was 143 F. The temperature logs on the units indicated "Temperatures in Warming Units Must Remain Between 90 and 160 Degrees Fahrenheit".</p> <p>2. At 1:40 PM on 02/18/14, staff member A22 indicated he/she monitored the temperatures and dated the fluids for one month in the warmer.</p> <p>3. During the tour of the Post Anesthesia Care Unit at 2:00 PM on 02/18/14, accompanied by staff member A20, a Getinge Warmer was observed in the clean utility room. The top chamber registered 104 degrees F. and contained six, undated 3000 milliliter bags of Baxter 0.9 Normal Saline irrigation fluid and the bottom chamber registered 142 degrees F. and contained blankets.</p> <p>4. At 2:15 PM on 02/18/14, staff members A23 and A24 on the unit indicated the irrigation fluid was stocked as needed and they did not know about date marking.</p> <p>5. During the tour of the Emergency</p>		<p>on the outer pouch of IV solution and on the bottle of normal saline/sterile water to indicate the date the solution will be discarded. The Patient Care Tech will monitor solutions daily to assure that no solution has exceeded their indicated time in the warming cabinet. No one is to place any non-designated solution or item in warming cabinet without permission. Each item in a warmer has to be researched to assure that the manufacturer's recommendation of placement in warming cabinets along with the correct temperature range for the item is correct. Temperature range for warming cabinets is monitored daily and documented on Warming Cabinet log in the ED and Peri-operative areas. Monthly warming cabinet logs are reviewed and maintained. If the temperature of a warming cabinet falls out of the manufacturer's recommendation, it is taken out of service and the Engineering Department is notified. Fluids in the peri-operative area outside the recommended temperature range will be discarded. Bath blankets will not be given to patients in the ED and peri-operative area when the warming cabinet temperature is outside the manufacturer's recommendation. The Peri-operative Services Director is responsible to assure temperature documentation of warming cabinet is complete for perioperative area and provide warming cabinet trends quarterly to Quality Council using the Measure of Performance Reporting form. The Director of ED is responsible to assure temperature documentation of warming cabinet in ED is complete and provide warming cabinet trends quarterly to Quality Council using the measure of Performance Reporting form. Quality Council quarterly submits service quality data to MEC and BOD committee.</p>		

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	<p>Department at 8:55 AM on 02/19/14, accompanied by staff member A10, a Getinge Warmer was observed in the nurses' station. The top chamber registered 117 degrees F. and contained individual bottles of ultrasound gel and the bottom chamber registered 131 degrees F. and contained blankets. The temperature monitoring log indicated the top chamber ranged between 115 and 117 F. and the bottom chamber ranged between 131 and 148 degrees F.</p> <p>6. The facility policy "Warming Cabinets", last revised 01/2011, indicated, "The temperature of warming cabinets in the OR shall be maintained according to manufacturer's recommendations. ...Verify with the manufacturers of irrigation solutions and IV solutions, temperature ranges and length of time the solutions may be stored in a warming cabinet."</p> <p>7. The User Manual for the Getinge Warmer indicated, "Burn Hazard- Do not exceed 150 degrees F. for non-vented closures (screw caps, crimp seals, plastic pouches, etc.) Do not exceed the solution manufacturer's temperature requirements. ...General: ...The temperature range is adjustable from 90 degrees to 160 degrees F. ...Burn Hazard: Items heated to over 120</p>			

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	<p>degrees F. can burn skin. Keep items that may contact skin at temperatures below 120 degrees F."</p> <p>8. At 1:00 PM on 02/19/14, staff member A20 indicated he/she was not aware of any actual warmer policy and thought the temperature log was created based on the manufacturer's manual which indicated the temperature range was 90 to 160 degrees F. He/she just obtained information from Baxter, the fluid manufacturer, which indicated the IV solutions could be warmed to 104 degrees F. for a period of no longer than 14 days.</p> <p>9. At 4:00 PM on 02/19/14, staff member A10 indicated the only information regarding warming of the ultrasound gel that he/she could obtain was the manufacturer's instructions regarding warming the gel in the Thermasonic Gel Warmer which was the system used in the Radiology Department. That information indicated the warmer had three settings, low, medium, and high, with the highest setting of 109 degrees F. The information lacked any directions regarding heating the gel in any other manner.</p>			

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S001197	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</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>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and staff interview, the facility failed to ensure the hospital had a routine fire safety inspection by either the state or local fire control agency as per hospital policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Fire Safety Management Plan policy #S 7.0 (Last revised October 30, 2013) indicated the hospital was to establish a Fire Department liaison to support fire inspections. 2. The Physical Plant documents were reviewed on 2/18/2014 with staff members' #8 and #18. The 	S001197	<p>S 1197 A request was sent to Perry-Clear Creek Fire Department on 2/18/2014 for a fire safety inspection. Policy revision to Inspection, Testing, Maintenance of Fire Alarm and Fire Suppression Systems F 1.1 includes an annual routine fire inspection request from a state Fire Marshall or from Perry-Clear CreekFire Department. 3/06/2014 the Hospital Wide Policy and Procedure Committee reviewed and approved the policy with no additional revision. Revised policy F 1.1 goes to MEC 3/18/2014 for review and approval. The Director of Support Services is responsible to rerquest the annual routine fire inspection. A reminder tickler system has been implemented 2/28/2014 to request the annual fire inspection.</p>	02/28/2014			

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	<p>facility could not produce evidence that the hospital had a fire safety inspection by either the state or local fire control agency.</p> <p>3. At 12:45 PM on 2/19/2014, staff member #8 indicated the facility does not have a liaison set up to conduct their routine state fire safety inspections. The facility was opened in 2006. August 16th, 2006; Perry Clear Creek Fire Protection District conducted the only fire safety inspection of the facility. The staff member indicated he/she never requested from either the state or local fire control jurisdiction to conduct a routine fire safety inspection of the hospital.</p>				