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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2013 |
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| S000000 | <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005075</p> <p>Survey Date: 12-16/20-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 12/30/13</p> | S000000 | | |
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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 its current hospital license in an area open to patients and the public in 1 instance.</p> <p>Findings:</p> <p>1. On 12-16-13 at 1:20 pm, in the presence of employees #A6 and #A13, it was observed in the hospital's main lobby area, the posted licensed expired 6-30-12.</p> | S000178 | <p>Each year when the license is renewed, the Director of Accreditation will provide the Administration administrative assistant with the new license to be posted in the public lobby. This deficiency was corrected during the survey. This process will prevent the deficiency from recurring the future. The director of accreditation is responsible. This deficiency was corrected on 12/16/2013.</p> | 12/23/2013 | |

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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 4 offsite services and 2 contracted services.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2013 indicated they did not include review of reports for the offsite services of St. Vincent Gynecologic Oncology, St. Vincent Maternal Fetal Medicine (Indianapolis), St. Vincent Vascular Lab 1st Floor and St. Vincent Women's Hospital Maternal Fetal Medicine (Fishers).</p> <p>2. In interview, on 12-20-13 at 10:10 am, employee #A2 confirmed the above</p> | S000270 | <p>1. St. Vincent Gynecologic Oncology, St. Vincent Maternal Fetal Medicine (Indianapolis), St. Vincent Vascular Lab 1st Floor and St. Vincent Women's Hospital Maternal Fetal Medicine (Fishers) will gather quality data on a monthly basis to be reviewed internally within each practice that will report the goals, outcomes and process improvement initiatives to the St. Vincent Indianapolis Quality Safety Committee(QSC).2. The above offsites have been added to submit and present their quality report to the hospital's QSC. This process will prevent this deficiency from reoccurring by ensuring accountability for reporting of quality measures for the above offsites. 3. First level responsibility will reside with the Practice Manager with second level responsibility residing with</p> | 01/14/2014 | | | |

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| | <p>and no further documentation was provided prior to exit.</p> <p>3. Review of the governing board minutes for calendar year 2013 indicated they did not include review of reports for the contracted services of 2 blood banks from which the hospital received blood.</p> <p>4. In interview, on 12-19-13 at 3:30 pm, employee indicated no blood bank quality activity reports were submitted to any hospital quality committee and no further documentation was provided prior to exit.</p> | | <p>the Executive Director of Specialty Practices. 4. The above offsites met on 1/14/14 to develop their quality measures. In addition, these sites have been added to the QSC schedule to present their quality reports. The offsite are scheduled to present semiannually to QSC starting in June 2014.</p> | | |

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| S000278 | <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(b)(2)(A)(B)(C)(D)</p> <p>(b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (2) Ensure that: (A) the requests of practitioners, for appointment or reappointment to practice in the hospital, are acted upon, with the advice and recommendation of the medical staff; (B) reappointments are acted upon at least biennially; (C) practitioners are granted privileges consistent with their individual training, experience, and other qualifications; and (D) this process occurs within a reasonable period of time, as specified by the medical staff bylaws. Based on interview and document review, the governing board failed to ensure that individuals granted privileges consistent with their request for privileges by certified surgical first assistant(CSFA) was performed (staff #4).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Bylaws indicated the following: "3.1-2. Appointment Process (a) All recommendations for appointment must also specifically</p> | S000278 | <p>1. All currently privileged CSFA's who harvest veins have received an additional privilege request to include vein harvesting. The privilege form for CSFA's shall be revised to include vein harvesting as a privilege to request along with appropriate privileging criteria. Once revised, the forms shall be sent through for appropriate committee approvals. 2. The manager of CVOR has been made aware that all credentialed CSFA's performing vein harvesting must be privileged to perform this procedure and will ensure that OR staff is aware. She has provided the additional</p> | 01/20/2014 | | | |

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| | <p>delineate which clinical privileges are recommended to be granted.</p> <p>8.4. Procedure for Appointment Each AHP, and the employer of each dependent AHP, shall file an application for appointment on a form provided by the Hospital. The procedure for evaluation and appointment shall be the same procedure as provided for members of the Medical Staff." The Medical Staff Bylaws were last reviewed/revise on 07-25-13.</p> <p>2. On 12-18-13 at 1630 hours, staff #40 confirmed that staff #4 performs the act of harvesting veins for open heart surgeries.</p> <p>3. Review of staff #4's credential/privileging file lacked documentation that staff #4 requested privileges to perform vein harvesting.</p> <p>4. On 12-19-13 at 0910 hours, staff #5 confirmed that staff #4's credential/privileging file lacked documentation of requesting the privilege to harvest veins.</p> | | <p>privilege request to all current CSFA's who perform the procedure. 3. Keith Hiatt, Director of Risk Management and Medical Affairs and Jennifer Murphy, Manager of CVOR shall share responsibility for 1 and 2 above.4. Medical Affairs will work to ensure that all additional privilege requests have received appropriate approvals by January 20, 2014.</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 4 offsite services as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2013, indicated they did not include monitors and standards for the offsite services of St. Vincent Gynecologic Oncology, St. Vincent Maternal Fetal Medicine (Indianapolis), St. Vincent Vascular Lab 1st Floor and St. Vincent Women's Hospital Maternal Fetal Medicine (Fishers).</p> | S000406 | <p>1. St. Vincent Gynecologic Oncology, St. Vincent Maternal Fetal Medicine (Indianapolis), St. Vincent Vascular Lab 1st Floor and St. Vincent Women's Hospital Maternal Fetal Medicine (Fishers) will gather quality data on a monthly basis to be reviewed internally within each practice that will report the goals, outcomes and process improvement initiatives to the St. Vincent Indianapolis Quality Safety Committee(QSC). 2. The above offsites have been added to submit and present their quality report to the hospital's QSC. This process will prevent this deficiency from reoccurring by ensuring accountability for reporting of quality measures for the above offsites. 3. First level responsibility will reside with the Practice Manager with second level responsibility residing with</p> | 01/14/2014 | | | |

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| S000554 | <p>2. In interview, on 12-20-13 at 10:10 am, employee #A2 confirmed the above and no further documentation was provided prior to 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 document review, observation and interview, the facility failed to ensure that staff used cleaning solution per manufacturer's recommendations and disinfected cleaning brushes after use and cleaned toys per the facility policy/procedure for 2 central sterile areas and 1 emergency department; failed to follow the manufacturer's instructions for testing the MetriCide Test Strips when a new bottle was opened in 1 instance and failed to store nutritional supplement according to the manufacturer's recommendation and failed to ensure the checking of supplies to prevent outdated usage and failed to ensure clean supplies and equipment were protected from contamination in four patient care areas (Neonatal</p> | S000554 | <p>the Executive Director of Specialty Practices. The above offsites met on 1/14/14 to develop their quality measures. In addition, these sites have been added to the QSC schedule to present their quality reports. The offsite are scheduled to present semiannually to QSC starting in June 2014.</p> <p>(items 1,2,3)1. The deficiency was corrected by:Establishing a process for trialing new products, which includes:a. Introduction/review of productb. Use manufacturer guidelines as specified to educate/train end users of productc. Record completed education dates for staff completing the education. 2. We will follow established process for trailing new products to prevent the deficiency from recurring in the future.3. The responsible party is the department manager of the area trialing product. 4. The deficiency was corrected immediately on 12-17-13.(items 4,5) 1. The deficiency was corrected by: Reviewed manufacturer instructions with</p> | 01/21/2014 | |

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| | <p>Intensive Care Unit, Pediatric Intensive Care Unit, Pediatrics 3rd floor, and Adult Med. Psych).</p> <p>Findings include:</p> <p>1. Review of the manufacturer's recommendations for the Revital-Ox 2X Concentrate Enzymatic Detergent indicated the following: "Discard solution after each manual cleaning per recommended practices."</p> <p>2. During the facility tour of the Central Sterile Processing area on 12-17-13 at 1150 hours the Revital-Ox 2X Concentrate Enzymatic Detergent was observed being used to clean dirty surgical instruments.</p> <p>3. On 12-17-13 at 1155 hours, staff #6 confirmed that he/she changes the Revital-Ox 2X Concentrate Enzymatic Detergent after using it to clean 3-4 uses.</p> <p>4. Review of the manufacturer's recommendations for the Key Channel Brushes and Key Fan Tip Brushes indicated the following: "They can be used several times as long as the brush bristles are firm enough to clean the instrument and the brush has been cleaned and decontaminated, at a</p> | | <p>staff using brushes immediately!</p> <ul style="list-style-type: none"> · Provided immediate education to all staff using brushes regarding manufacturer instructions for using brushes to clean instruments. · Key Channel Brushes will be used one time and discarded per manufacturer's guidelines. · Key Fan Tip Brushes will be disinfected daily per manufacturer's guidelines. <p>2. Staff processing instruments were instructed to follow manufacturer guidelines per St. Vincent policy and procedure this wil prevent the deficiency from recurring in the future.3. Responsible party is the department manager of the area.4. This situation was corrected immediately 12-17-13 (items 6,7,8)1. This deficiency will be corrected by:</p> <ul style="list-style-type: none"> · Infection Prevention and Touch Point will review current options for hospital approved disinfection products. · Review toy cleaning policy and procedure best practices with pediatrics representatives. · Meet with pediatric leadership to decide which best practices to adopt and revise policies and procedures to reflect that practice. · Educate front line staff regarding revised policy and procedure and expectations around toy cleaning and disinfection. <p>2. Adoption of best practices around toy cleaning and use these practices to assist with revision of current</p> | | |

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| | <p>minimum daily, prior to reuse."</p> <p>5. On 12-17-13 at 1245 hours, staff #7 confirmed that he/she does not disinfect cleaning brushes after using them to clean dirty instruments.</p> <p>6. Review of policy/procedure Toy Cleaning, Peyton Manning Children's Hospital indicated the following; "A. All small toys must be disinfected with a hospital approved disinfectant, followed by warm water rinse between individual patient use before returned to the play area." This policy/procedure was last reviewed/revised on 05/12.</p> <p>7. During the facility tour of the Pediatric Emergency Department (ED) on 12-16-13 at 1330 hours in the presence of staff #41, ED staff confirmed that they use Sani-Wipe to clean toys after patient use.</p> <p>8. On 12-16-13 at 1540 hours, staff #50 confirmed that Infection Control did not recommend the use of Sani-Wipe to disinfect toys.</p> <p>9. During the facility tour of the ED on 12-16-13 at 1300 hours, the following was observed at the triage area: The patient care equipment such as the</p> | | <p>policy and procedure will prevent the deficiency from recurring in the future. 3. Infection Prevention, Pediatric leadership, and EVS leadership will be responsible for the above plan of correction.4. The deficiency will be corrected by 01-20-14. (items 9,10,11)1. ED staff will be re-educated regarding the standard policy and procedure and expectations of cleaning and disinfection of equipment and surrounds after providing patient care in the triage area.2. Random observations and feedback along with just in time education will be provided to staff working in triage areas.3. Manager of ED is responsible for this plan of correction.4. This deficiency will be corrected on January 27, 2014 (items 12,13)1. We corrected the deficiency by implementing a new form. This form went into effect on 12/31/13.2. This deficiency will not happen in the future as we will annually review the Metricide cleaning process. This will be part of their mandatory education.3. The supervisor Laura Roth will be responsible for this plan of correction.4. This deficiency was corrected on 12/31/13.(items 14,15,16) 1. We corrected the deificiency by educating the staff on the dock on the importance of keeping the Similac formula covered to prevent the product from being exposed to light. 2. The</p> | | | | |

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| | <p>blood pressure cuff was not disinfected between patients.</p> <p>10. On 12-16-13 at 1325 hours, staff #41 confirmed that patient care equipment is supposed to be cleaned with Claviwipes between patients.</p> | | <p>director of facilities will monitor compliance with the above plan of correction during environment of care rounds. This monitoring will prevent this deficiency from reoccurring.3. The director of facilities will be responsible for this plan of correction.4. This deficiency was corrected on 1/21/14(items 17,18,19)1. The process was currently in place for the CST's to restock the anesthesia carts. Leadership is meeting with CST team 1/21/14 to reinforce education on the process. Stocking will occur with the replacement of new products at the back of the carts, therefore moving older items forward. They will also implement the current Code Cart replacement/stocking process.Pharmacy currently stocks and will continue to stock and check for expiration of medications. 2. The CST team will be held accountable to leadership. Bi-weekly cart evaluations will be conducted, beginning 1/21/14. 3. The manager of the L&D and director of the L&D will be monitoring compliance. Coaching and education will follow if needed.4. Communication , education and processes will be in place by 1/21/14. We will continuously monitor and improve on the process as needed. (items 20,21,22,23)1. This deficiency will be corrected by reeducating staff on the</p> | |

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| | <p>11. Review of the manufacturer's recommendation on the test strip bottle for test strips used for MetriCide, indicated testing of positive and negative controls must be performed on each newly opened bottle of MetriCide OPA Plus Solution Test Strips.</p> <p>12. On 12-17-13 at 11:40 am, review of the Test Strip Log for MetriCide, located in Ultrasound Room Scan 6, indicated there was no documentation of testing of positive and negative controls on each newly opened bottle of MetriCide OPA Plus Solution Test Strips.</p> <p>13. On the above date and time, an ultrasound staff person indicated there was no documentation of this testing and no further documentation was provided prior to exit.</p> <p>14. On 12-18-13 at 11:50 am in the</p> | | <p>importance of not storing cardboard boxes on the floor in the formula /clean supplies room. 2. The managers of each area will conduct routine rounds in these areas to ensure that cardboard boxes are not being stored on the floor. 3. The managers of these areas will be responsible for this plan of correction. 4. The deficiency will be corrected by 1/21/14.</p> | |

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| | <p>presence of employee #A6, it was observed in the General Stores area there were the following stored on an open shelf, uncovered, unprotected, and exposed to the light:</p> <p>23 2 oz. bottles Similac Soy Isomil supplement 19 2 oz. bottles Similac Advanced Complete Nutrition</p> <p>15. Review of the manufacturer's label on each bottle indicated Avoid Extreme Temperatures and Exposure to Light.</p> <p>16. Due to the prolonged exposure to light, the above items may have become ineffective.</p> <p>17. During the tour of the C/S surgical area of the Women's Health Center at 11:15 AM on 12/17/13, accompanied by staff member A6, the following items were observed in the anesthesia cart in room 2:</p> <p>A. Lidocaine Hydrochloride solution kit, 3 of 3, with an expiration date of 1 Sept. 2012.</p> <p>B. Light Wand Lighted Stylet, 3 of 3, with an expiration date of 08/2013.</p> <p>C. One open, sterile package of a Light Wand Lighted Stylet with an expiration date of 09/2009.</p> <p>D. Level I Acoustascope Esophageal Stethoscope, 3 of 3, one expired 06/2011</p> | | | | |

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| | <p>and two expired 11/2011.</p> <p>E. Tube Stat Oral Intubation Stylet, 2 of 2, one expired 02/17/10 and one expired 09/29/12.</p> <p>18. At 11:20 AM on 12/17/13, staff member A6 indicated anesthesia staff, not nursing, was responsible for the anesthesia supplies and equipment.</p> <p>19. During the tour of the hallway in the C/S surgical area at 11:30 AM on 12/17/13, accompanied by staff member A6, the following items were observed in the mobile anesthesia cart:</p> <p>A. Angiocaths, 4 of 4, 14 gauge, one expired 06/2006 and three expired 01/2009.</p> <p>B. Satin-Slip Stylet, 3 of 3, with an expiration date of 09/2013.</p> <p>C. Light Wand Lighted Stylet, 2 of 2, with an expiration date of 09/2013.</p> <p>D. Tube Stat Oral Intubation Stylet, 2 of 2, one expired 01/27/10 and one expired 02/27/10.</p> <p>E. Laryngeal Masks, 4 of 4, with an expiration date of 05/2007.</p> <p>F. Glidescope Cobalt Ranger, 6 of 6, four expired 10/27/11, one expired 11/19/11, and one expired 09/13/13.</p> <p>20. During the tour of the Neonatal Intensive Care Unit at 2:20 PM on 12/17/13, accompanied by staff</p> | | | | | | |

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| | <p>members A8, A18, and A19, two large cardboard shipping boxes were observed stored on the floor in the formula/clean room near other clean supplies.</p> <p>21. During the tour of the Pediatric Intensive Care Unit at 9:30 AM on 12/18/13, accompanied by staff members A21 and A22, several cardboard shipping boxes were observed in the formula/clean room near other clean supplies and bottles of formula.</p> <p>22. During the tour of the 3rd floor Pediatric Unit at 10:30 AM on 12/18/13, accompanied by staff members A21 and A23, several cardboard shipping boxes were observed in two clean rooms near other clean supplies.</p> <p>23. During the tour of the Adult Med. Psych Unit at 11:20 AM on 12/18/13, accompanied by staff members A21 and A25, a cardboard shipping box was observed in the pantry near other clean supplies.</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 documentation review, observation, and staff interview, the facility failed to maintain clean and sanitary conditions in the Clean Linen Storage Room and proper storage of clean linen in a transport cart located at one off-site.</p> <p>Findings included:</p> <p>1. St. Vincent Hospital policy #38130 (ast approved 9/2012) indicated clean linen shall be stored in a sanitary manner. Soiled linen shall be placed in</p> | S000612 | (item 1, 2,3,4,5)1. The EVS director provided education on the importance of ensuring the entire unit is cleaned including the top of storage shelves of the uncovered clean linen. In addition, both EVS and nursing staff were educated on the proper place to dispose of dirty yellow isolation gowns.2. The managers and directors of both EVS and nursing will conduct routine rounds to inspect cleanliness and proper disposal of dirty yellow isolation gowns. 3. The manager of EVS and nursing unit managers are both responsible for the above plan of correction.4. This deficiency was corrected on 1/17/14 | 01/17/2014 | | | |

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| | <p>clear plastic bags and returned to the appropriate dirty linen collection site.</p> <p>2. At 11:15 AM on 12/17/2013, the off-site Clean Linen Storage Room was inspected. The top storage shelves of the uncovered clean linen were heavily caked with dust and other soil residue.</p> <p>3. At 11:25 AM on 12/17/2013, a clean linen storage cart located in the maintenance hallway of the off-site was observed to the bottom right of the cart, uncovered unfolded yellow isolation gowns lying next to a bag of clean linen towels.</p> <p>4. At 11:30 AM on 12/17/2013, staff member AD1 indicated the yellow uncovered isolation gowns were dirty because a nurse from one of the floors dropped them on the floor and just threw them into the clean linen cart.</p> <p>5. At 11:35 AM on 12/17/2013,</p> | | | |

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| S001014 | <p>staff member AD2 indicated the Clean Linen Storage Room needed the shelving units dusted. The staff member confirmed the dirty isolation gowns should have been placed on the dock which was located through the double doors next to the clean linen storage cart.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on documentation, interview and observation, the hospital failed to appropriately control who had access to medications in 3 instances.</p> <p>Findings:</p> <p>1. Review of the hospital's formulary indicated sodium chloride Irrig Soln</p> | S001014 | <p>1. In our policy we utilize the words "Medication administration." This language implies access to medications. However, we recognize that this language is not explicit and thus have made edits to the policy to be clearer about who has the authority to administrator medication. In addition, we have edited this policy to explicitly identify who has authority and</p> | 01/10/2014 | |

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| | <p>0.9% was included as part of the formulary.</p> <p>2. Hospital staff was requested to provide a written policy of who was authorized to access medications. No documentation was provided prior to exit.</p> <p>3. Review of PolicyStat ID: 30279, entitled Security of Medication Storage Areas, approved 4/2010, indicated [the] RESPONSIBILITY/AUTHORITY [of the policy applied to] medical staff, nursing staff, nurse anesthetists, respiratory therapists, pharmacy staff, and others who are authorized by policy to administer medications. This policy did not specifically state who had authority to access medications and no other documentation was provided prior to exit.</p> <p>4. On 12-16-13 at 2:10 pm in the presence of employees #A6 and #A13, it was observed in the Physical Therapy clean utility room there were 3 boxes of AddiPak medication containing 144 15 ml vials each of 0.9% sodium chloride solution stored in a locked cabinet.</p> <p>5. In interview, at the above date and time, a hospital staff person who opened the locked cabinet indicated he/she was</p> | | <p>approval to access the medication. Education was provided to staff on these policy changes. The occupational therapists and maintenance staff were reeducated on this policy and reinforced that they do not have authority to access areas in which medication is stored. 2. Rehabilitation services, nursing and pharmacy leadership will conduct ongoing monitoring to prevent this deficiency from reoccurring.3. Nursing, Rehabilitation services and pharmacy directors are all responsible for the above plan of correction. 4. This deficiency was corrected on 1/10/14.</p> | | | | |

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| | <p>an Occupational Therapist. This person was not authorized by hospital policy to access medications.</p> <p>6. On 12-18-13 at 11:55 am in the presence of employees #A6, it was observed in the General Stores room there was stored 4 boxes of AddiPak medication each containing 144 15 ml vials of 0.9% sodium chloride solution.</p> <p>7. In interview, on 12-18-13 at 11:55 am, a General Stores staff person indicated the room was accessed by maintenance personnel when General Stores staff were not in the room. The maintenance staff were not authorized by hospital policy to access this medication.</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, interview, and policy and procedure review, the facility failed to ensure all medications were secured from unauthorized access.</p> <p>Findings included:</p> <p>1. During the tour of the C/S surgical area of the Women's Health Center at 11:15 AM on 12/17/13, accompanied by staff member A6, room 2 was observed unstaffed and unattended, and being cleaned by environmental staff member A33. Tour of the room indicated an unlocked and unsecured anesthesia cart containing numerous medications and supplies.</p> <p>2. At 11:20 AM on 12/17/13, staff member A6 indicated the</p> | S001028 | <p>1. An email was sent out by the Medical Director of Anesthesia to the group stating the situation and expectation to be 100% compliant in locking anesthesia carts or be financially fined for violations. This email was sent out 12/30/13.2. Our CSTs will be going over a checklist at the beginning of their shifts in each OR and signing of, similar to the process of a code cart. We are also going to be setting our anesthesia carts up much like code carts to easily be able to identify outdated supplies. This process will be implemented by 1/21/14.3. The manager of the L&D and director of the L&D will be monitoring the sign off checklists throughout the week to monitor compliance. Coaching and education will follow if needed.4.</p> | 01/21/2014 | | | |

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| | <p>anesthesiologist usually comes back to restock the cart after each case, but confirmed the cart was unsecured from unauthorized access.</p> <p>3. During the tour of the hallway in the C/S surgical area at 11:30 AM on 12/17/13, accompanied by staff member A6, the mobile anesthesia cart, containing medications and supplies, was observed unstaffed and unattended, but unsecured despite a plastic lock attached. Staff member A6 confirmed the lock was not secured properly to prevent unauthorized access.</p> <p>4. The facility policy "Security of Medication Storage Areas", last reviewed 04/2012, indicated, "B. All medications will be kept secured at all times. Medications are considered to be 'Secured' when locked or under surveillance by an authorized person (nurse, physician, pharmacist, or other hospital authorized associate) in the immediate area to observe that no unauthorized person (patient, visitor, maintenance, housekeeping, etc.) might have access to the medication."</p> <p>5. The facility policy "Department of Anesthesia- Safety Practice Guidelines", last reviewed 08/2013, indicated, "D. Anesthesia drug carts and medications</p> | | Communication, education and processes will be in place by 1/21/14. We will continuously monitor and improve on the process as needed. | | |

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| S001164 | <p>on anesthesia machines are considered to be controlled between cases as long as OR personnel are present in the room. Drug carts are locked when the room is unattended by personnel."</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. Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 2 pieces of equipment.</p> <p>Findings:</p> <p>1. On 12-16-13 at 3:30 pm, employee #A6 was requested to provide documentation of PM on a True Elliptical 4 exercise machine and a Detecto scale, both located in the Associates Fitness area.</p> <p>2. By exit, no PM documentation was provided for the above pieces of</p> | S001164 | <p>1. We notify the YMCA who is contracted to manage our associate gym of the need to conduct PM checks on all equipment used by associates. The YMCA agreed to begin to keep a log of the equipment PM.2. The director of rehabilitation services oversees the contract with YMCA and will conduct ongoing monitoring of PM checks on equipment.3. The director of rehabilitation services will be the person responsible for the above deficiency.4. This deficiency was corrected on 1/10/14.</p> | 01/10/2014 | |

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| S001168 | <p>equipment</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, interview, manufacturer's directions, and policy and procedure review, the facility failed to ensure the defibrillator checks were performed according to policy and manufacturer's instructions.</p> <p>Findings included:</p> <p>1. During the tour of the Post Partum Unit at 1:30 PM on 12/17/13, accompanied by staff members A8 and A17, a Zoll M defibrillator was observed on the crash cart with a log of checks for December 2013. Staff member A17 indicated the defibrillator was checked twice daily. Review of the logs for the last 4 months indicated:</p> <p>A. Nine days in September 2013 with only one check and one day without any checks.</p> | S001168 | <p>1. The policy and procedure on defibrillator inspection and checks was reviewed with unit staff. In addition, education and training on proper defibrillator inspection was conducted. 2. To prevent this deficiency from reoccurring defibrillator inspection and log will be completed according to policy. In addition, unit manager/nursing leadership will validate 100% compliance daily for 30 days and provide reeducation and training as identified. Unit manager/nursing leadership will validate compliance via random checks monthly thereafter. 3. The unit manager will be the person responsible for this plan of correction. 4. This plan of correction was completed on 1/17/14.</p> | 01/17/2014 | | | |

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| | <p>B. Thirteen days in October 2013 with only one check and two days without any checks.</p> <p>C. Twelve days in November 2013 with only one check and two days without any checks.</p> <p>D. Eight days in the first half of December 2013 with only one check.</p> <p>2. During the tour of the Pediatric Intensive Care Unit at 9:30 AM on 12/18/13, accompanied by staff members A21 and A22, Heartstart defibrillators were observed on the crash carts with logs of daily checks for December 2013. Both logs lacked twice daily checks for 4 days in the first half of December 2013. Staff member A22 indicated the defibrillators should be checked twice daily.</p> <p>3. During the tour of the Acute Rehab Unit at 10:55 AM on 12/18/13, accompanied by staff member A32, a Zoll M defibrillator was observed on the crash cart with a log of checks for December 2013. Staff member A32 indicated the defibrillator was checked twice daily. Review of the logs for the last 3 months indicated:</p> <p>A. Eleven days in October 2013 with only one check and two days without any checks.</p> <p>B. Eight days in November 2013 with</p> | | | |

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| | <p>only one check and two days without any checks.</p> <p>C. Nine days through December 18, 2013 with only one check and one day without any checks.</p> <p>4. During the tour of the Senior Psychiatric Unit at 11:30 AM on 12/18/13, accompanied by staff members A21 and A26, a Zoll M defibrillator was observed on the crash cart with a log of daily checks for December 2013. Review of the log for November 2013 indicated 7 days with only one check.</p> <p>5. The manufacturer's directions for the Zoll M Series defibrillator indicated, "Because the M series units must be maintained ready for immediate use, it is important for users to conduct the Operator's Shift Checklist procedure at the beginning of each shift."</p> <p>6. The facility policy "Defibrillator Inspection", last reviewed 06/2012, indicated, "Note 4: Inspection is to be done at beginning of shift. Shift is defined as 12 hours. Areas that are open less than 12 hours are required to perform inspections at beginning of shift."</p> | | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/20/2013 | |
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| S001172 | <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation and interview, the facility failed to provide environmental services according to safe practice and to prevent cross infection between patients in the Pediatric building.</p> <p>Findings included:</p> <p>1. During the tour of the Pediatric Intensive Care Unit at 9:30 AM on 12/18/13, accompanied by staff members A21 and A22, the wall shelves containing emergency equipment were observed coated with heavy layers of dust. Room 3, ready for a new patient, was observed with soiled linen still in the bin in the room and dried material</p> | S001172 | <p>1. The EVS director provided education on the importance of ensuring the entire unit is cleaned including the top of storage shelves of the uncovered clean linen. In addition, both EVS and nursing staff were educated on the proper place to dispose of dirty yellow isolation gowns.2. The managers and directors of both EVS and nursing will conduct routine rounds to inspect cleanliness and proper disposal of dirty yellow isolation gowns.3. The manager of EVS and nursing unit managers are both responsible for the above plan of correction.4. This deficiency was corrected on 1/17/14</p> | 01/17/2014 | | | |

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| | <p>was observed on a slide-out supply drawer.</p> <p>2. At 9:35 AM on 12/18/13, staff member A22 confirmed the room was supposed to be cleaned and ready for a new patient.</p> <p>3. During the tour of the 3rd floor Pediatric Unit at 10:30 AM on 12/18/13, accompanied by staff members A21, A23, and A24, five large, clean, chemo containers were observed in the soiled utility room along side soiled items and used biohazard containers. Room 3005, ready for a new patient, was observed with soiled lined still in the bin in the room. A large, soiled, dried sticky area was observed on the counter top in the room.</p> <p>4. At 10:35 AM on 12/18/13, staff member A23 indicated the containers would be used for soiled chemo items, but should not be stored in the soiled room prior to use. He/she also indicated the room was supposed to be cleaned for a new patient.</p> | | | | |