

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150084	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260
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S 0000 Bldg. 00	This visit was for standard licensure survey. Facility Number: 005075 Survey Date: 4-27/30-2015 QA: cjl 05/18/15 IDR Committe held on 06-17-15; Tag 1160 findings moved to ATag 1118 & Tag A1166 deleted. JL	S 0000		
S 0178 Bldg. 00	410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a) (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. Based on observation, the hospital failed to conspicuously post the hospital's current license in an area open to patients and the public in 2 offsite facilities. Findings:	S 0178	S 178: Posting of License Corrective Action(s): On or before April 30, 2015, a copy of the hospital's current license was conspicuously posted in an area open to patients and the public at 1) The Stress Center building in the reception area and 2) Cancer	04/30/2015

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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	<p>interview, the governing board failed to review reports of Quality Assurance activities for 32 hospital offsite housekeeping contracted services and 1 contracted service, laundry, for the calendar year 2014.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The 2014 Quality Assessment and Performance Improvement Program indicated all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. Each service shall be monitored for defined standards. If the standards are not met; an action plan shall be addressed that notes the outcomes of each documented action plan. The governing board shall review all services that have direct or indirect impact to patient care. St. Vincent Hospital and Health Services has 36 offsite facilities that are under the hospital license. There are 32 of 36 offsite locations 		<p>review reports of Quality Assurance activities for 32 hospital offsite housekeeping contracted services and 1 contracted service, laundry for the calendar year of 2014. Quality reports for these areas will be reviewed at the Quality and Safety on July 24th 2015, and reported to the Governing board on October, 2015.</p> <p>Responsible Person(s): The Executive Director of Quality or her designee will monitor these corrective actions to ensure that the deficiency is corrected and will not recur.</p>	

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	<p>that have a contract or an agreement with a housekeeping company to provide services to the offsite facilities.</p> <p>3. At 2:15 PM on 4/29/2015, staff member #A1 (Executive Director of Quality) confirmed the hospital has 32 offsites that the housekeeping services are not monitored to their effectiveness. The staff member indicated he/she could not provide written documentation on the effectiveness of their housekeeping programs. The staff member also concluded that the Governing Board did not evaluate the housekeeping services of the 32 offsite locations.</p> <p>4. Review of the governing board minutes for calendar year 2014 indicated they did not include review of reports for the contracted service of laundry.</p> <p>5. In interview, on 4-30-2015 at 11:25 am, employee #A1, Executive Director of Quality, confirmed the above and no further documentation was provided prior to exit.</p>			

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S 0406 Bldg. 00	<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 32 offsite location housekeeping services had no quality assurance monitors that included the standards and outcomes of the services that were provided.</p> <p>Findings included:</p> <p>1. The 2014 Quality Assessment and Performance Improvement Plan indicated all services with direct or indirect impact on patient</p>	S 0406	<p>S406-Quality Assessment and Improvement- Failed to ensure 32 offsite location housekeeping services had no quality assurance monitors that included standard and outcomes of the services that were provided. Corrective Action (s): On June 1, 2015, St Vincent Quality leadership met with departments including contractors to ensure that developed performance improvement indicators as part of the organizational QAPI plan by date. Each area will report results of their PI monitors at a minimum of twice yearly at the Hospital Quality Council on August 28, 2015. The performance indicators for the services listed above will be the</p>	06/04/2015

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	<p>care quality shall be reviewed under the quality improvement program. Each service shall be monitored for defined standards. If the standards are not met; an action plan shall be addressed that notes the outcomes of each documented action plan.</p> <p>2. St. Vincent Hospital and Health Services has 36 offsite facilities that are under the hospital license. There are 32 of 36 offsite locations that have a contract or an agreement with a housekeeping company to provide services to the offsite facilities. The 32 offsite locations with housekeeping services are not monitored through the hospital Quality Assurance Performance improvement program.</p> <p>3. At 2:15 PM on 4/29/2015, staff member #A1 (Executive Director of Quality) confirmed the hospital has 32 offsites that the housekeeping services are not monitored to their effectiveness.</p>		<p>following: 32 offsite location housekeeping service indicators-</p> <ol style="list-style-type: none"> 1. Customer service satisfaction survey-specifically if contracted housekeeping services is consistently meeting expectations, as evidenced by, but not limited to the indicators listed below. 2. Trash is emptied 3. No visible dust 4. Area is cleaned daily 5. Concerns should be reported to <p>Responsible Person (s): The Executive Director of Quality or her designee will monitor these corrective actions to ensure that the deficiency is corrected and will not recur.</p>	

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S 0596 Bldg. 00	<p>The staff member indicated he/she could not provide written documentation on the effectiveness of their housekeeping programs.</p> <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 interview and observation, the facility failed to ensure that bronchoscopy scopes were cleaned and processed every 7 days.</p> <p>Findings:</p>	S 0596	<p>S596-Infection Control- failed to ensure that a bronchoscopy scope was cleaned and processed every 7 days. Corrective Action (s): On April 29, 2015, while the surveyor was still onsite, a new process was put into place to ensure unit</p>	06/04/2015

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	<p>1. On 4/29/15 at 1500 hours, staff # 23 (Infection Practitioner) verified that the facility follows CDC (Center for Disease Control) guidelines for the cleaning and processing of bronchoscopy scopes. He/she verified that based on these guidelines that the bronchoscopy scopes need to be cleaned and processed after each use or every 7 days if the bronchoscopy scope has not been used. He/she verified that the bronchoscopy scope on the Pediatric Intensive Care Unit had not been processed in the last 7 days. He/she also verified that there is not a system to date and monitor the bronchoscopy scope on the Pediatric Intensive Care Unit.</p> <p>2. On 4/28/15 at 1130 hours, the Pediatric Intensive Care Unit was toured with staff # 24 (Nursing Director) and staff# 25 (Nurse Manager) was toured. A bronchoscopy scope was observed stored on the unit on an emergency cart. There was no evidence showing the last date that the bronchoscopy scope was cleaned and processed. Staff #25 indicated that he/she did not know when the bronchoscopy scope was last cleaned and processed.</p>		<p>based bronchoscopes are cleaned and processed within seven days per policy and are safe and ready for patient use at all times. Further, any bronchoscope that is not used within 7 days (as indicated by a dated tag) will immediately be taken to Digestive Health for processing via the Charge Respiratory Therapist or his/her designee. The cleaned bronchoscope will be returned to the unit with a new tag attached to the scope that indicates the date of processing along with a colored dot that corresponds to that day. This will mirror the process that is currently used in Digestive Health. Every day, on day, shift a therapist will be responsible for checking the bronchoscope to ensure they have been cleaned within the 7 day shelf life per policy and will notify the Charge Respiratory Therapist or his/her designee of any scopes at the seven day threshold. Beginning on April 29, 2015, Pediatric Intensive Care Unit respiratory therapists and nurses were educated as to the new process for dating and monitoring the cleaning and processing of the unit based bronchoscopes. Education was completed on or before April 29, 2015 with immediate implementation. Any requisite staff members who fail to complete the education within the designated timeframe will be</p>		

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			<p>required to complete this task on an individual basis upon returning to work. Beginning in June 2015, education regarding policy and procedure expectations will be added to the curriculum for new PICU Respiratory Therapists and nurses. Documentation of education will be maintained.</p> <p>Monitoring: To ensure compliance beginning in June 2015, St. Vincent PICU Respiratory leader or his/her designee will initiate a monthly audit to ensure the bronchoscope on the emergency cart in the PICU has been cleaned and processed within at least 7 days and is safe and ready for patient use. Any identified gaps will immediately be discussed with the Respiratory Supervisor on the PICU on an individual basis for performance improvement. This audit will be completed for a 3-month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of the audits will be communicated through the PICU quality monitoring process.</p> <p>Responsible Person (s): Respiratory Supervisor or his/her designee will be responsible for</p>	

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S 0608 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure the surgical staff followed their dress code policy and nationally recognized guidelines regarding surgical masks.</p> <p>Findings included:</p> <p>1. Review of the facility policy "Surgical Attire", last reviewed 12/2014, indicated, "2. Masks must be removed and</p>	S 0608	<p>ensuring that staff has a clear understanding of when the bronchoscope should be cleaned and processed and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur.</p> <p>S608 –Infection Control –failed to ensure the surgical staff followed their dress code policy Corrective Action (s): On or before June 4, 2015, Main Operating Room surgical staff (including Pediatric Operating Room) and Cardiovascular Operating Room staff were reeducated regarding the importance of following the Surgical Attire policy with special emphasis on proper use and discard of OR</p>	06/04/2015

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	<p>discarded immediately following a procedure, must be changed when they are contaminated, and should be removed upon leaving the restricted area. 3. Masks may not be dangled around the neck or be placed in pockets after use."</p> <p>2. During the tour of the main surgery department between 9:35 AM and 10:20 AM on 04/28/15, accompanied by staff member S13, the Surgery Manager, six different staff members were observed walking in and out of rooms, standing in doorways talking, and getting on an elevator with surgical masks hanging around their necks or chins, with one hanging on one ear.</p> <p>3. During the tour of the Cardiovascular Operating Room (OR) area at 11:05 AM on 04/28/15, accompanied by staff member S17, the area manager, one staff member wearing a lead apron and a surgical mask hanging on one ear was observed walking through the hallway. Another staff member was observed outside the empty Pediatric OR talking with another staff member while wearing a surgical mask around the chin.</p> <p>4. At 11:30 AM on 04/28/15, staff member S13 and staff member S16, the Infection Preventionist, confirmed the facility followed AORN Guidelines</p>		<p>surgical masks both inside and outside of operating room suites. Specifically, education included that masks will be removed and discarded in a trash can following a procedure, removed upon leaving a restricted area, and proper placed securely on the staff member's face and not hanging on the chin or one ear. Education was completed on or before June 4, 2015, with immediate implementation. Any requisite staff members who fail to complete the education within the designated timeframe will be prohibited from working with Operating Room patients until documentation of completion is provided. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work.</p> <p>Monitoring: To ensure compliance, beginning June 2015, Director of Surgical Services or her designee will initiate a monthly observational audit of operating room attire to ensure the policy is being adhered to and masks are being worn and discarded in an appropriate manner. Any identified gaps will immediately be discussed with the OR staff member on an individual basis for performance improvement. This audit will be completed for a 3-month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the</p>	

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S 0930 Bldg. 00	<p>(Association of PeriOperative Registered Nurses) which indicated surgical masks were to be changed between cases and not worn around the neck or stored in pockets.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on policy and procedure review, medical record review, and interview, the registered nurse failed to evaluate the effectiveness of prn (as needed) medication in the care of two of two patients who received as needed medication in the Stress Center (#6 and #7).</p>	S 0930	<p>auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of the audit will be communicated through Operating Room quality monitoring process.</p> <p>Responsible Person (s): The Director of Surgical Services will be responsible for ensuring that OR staff has a clear understanding of Surgical Attire policy and how to properly don and discard of surgical masks and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur.</p> <p>S930-Nursing Service-failed to evaluate the effectiveness of prn (as needed) medication in the care of two of two patients who received as needed medication in the Stress Center.</p> <p>Corrective Action (s): St. Vincent Stress Center nurses were reeducated regarding the</p>	06/04/2015

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	<p>Findings included:</p> <p>1. Review of the facility policy "Pain Management: Adult and Pediatric", last reviewed 11/2013, indicated, "Pain intensity, description, and pain relief as reported by the patient will be assessed, treated as appropriate, and documented. ...After each pain management intervention, once a sufficient time period has elapsed for treatment to reach peak effect. ...PO [by mouth] immediate-release medications must be reassessed within 90 minutes."</p> <p>2. Review of the facility policy "Patient Assessment/Reassessment", last reviewed 09/2012, indicated, "Reassessment: Purpose: To evaluate the patient's response to care, treatment, and services. ...Planning for care, treatment, and services includes the following: ...Monitoring the effectiveness of care planning and the provision of care, treatment and services."</p> <p>3. Review of the facility policy "Patient Plan of Care", last reviewed 10/2014, indicated, "2. Assessment intervention flow sheet: ...b. Promotes documentation of assessments and interventions that demonstrate implementation of the plan of care, including patient response and</p>		<p>importance of documenting reassessment of patient in the medical record to ensure whether medication was successful or not in alleviating patient's symptom. Education will be completed on or before June 4, 2015, with immediate implementation. Any requisite staff members who fail to complete the education within the designated time frame will be prohibited from working with Stress Center patients until documentation of completion is provided. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work. Beginning, June 2015, education regarding documentation of patient reassessment following administration of a prn or as needed medication will be added to the curriculum of Stress Center Nursing staff. Documentation of education will be maintained.</p> <p>Monitoring: To ensure compliance, beginning June 2015, the Stress Center Director or her designee will initiate a monthly audit of 30 patients per month of all PRN, or as needed, medications given during a 24 hour period of time to ensure that the reassessment of the patient was performed and documented in the medical record. Any identified gaps will immediately be discussed with the Stress Center nurse on an</p>	

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	<p>progress."</p> <p>4. The medical record for patient #6 indicated a physician order for Morphine Immediate Release 30 mg. (milligrams) orally four times daily prn for pain. The record indicated the patient received the medication at 0826 hours on 12/28/14 for a reported back pain of 5 (on a 1- 10 scale), but wasn't reassessed until 1240 hours on 12/28/14. The record indicated the medication was given again at 0738 hours on 12/29/14 for a reported pain of 7, but was not reassessed until 1240 hours on 12/29/14. The patient received the medication at 0021 hours on 12/31/14 for a reported pain of 5 and was reassessed at 0233 hours on 12/31/14, over two hours later. Another dose of medication was given at 1225 hours on 01/02/15 for a reported pain of 5 and was reassessed at 1405 hours on 01/02/15, which was timely, but the assessment indicated, "Pain reassessment: 'It's been a really bad today. I don't always take all four of the pain pills. I shouldn't have done the yoga.' " The effectiveness of the medication was not really documented.</p> <p>5. The medical record for patient #7 indicated a physician order for Alprazolam 0.5 mg. orally four times a day prn for anxiety. Medical record documentation indicated the patient</p>		<p>individual basis for performance improvement. This audit will be completed for a 3-month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of the audits will be communicated through the Nursing Services quality monitoring process.</p> <p>Responsible Person (s): The Stress Center Director or her designee will be responsible for ensuring that Stress Center Nursing staff has a clear understanding of the importance to reassess the patient after administering a prn as needed medication and document the reassessment in the medical record as evidence the intervention was effective and monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur.</p>		

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S 1118 Bldg. 00	<p>received the medication at 1107 hours and 1855 hours on 12/29/14; at 0626 hours, 1408 hours, and 2043 hours on 12/30/14; at 0641 hours, 1245 hours, and 1849 hours on 12/31/14; and at 0642 hours and 1249 hours on 01/01/15. The record lacked any documentation to indicate the effectiveness of any of the doses of the medication.</p> <p>6. At 11:30 AM on 04/30/15, staff member #S18, the Director of the Stress Center, confirmed the lack of documentation for the prn medications. He/she indicated the unit previously had used a PRN Medication Outcome Record form, but since a lot of the documentation was on the Electronic Medical Record now, the form was no longer used. He/she indicated the effectiveness of any medications, care, or treatment should be documented.</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</p>						

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	<p>maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on documentation review, observation, and staff interview, the hospital failed to maintain the environment in such a manner that the safety and well-being of patient, staff, and visitors are assured in the Maintenance Shop, Floor Care Equipment Room, receiving dock, Cancer Center building radiology area room 1, Women's Hospital medical gas storage area and 1 defibrillator.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The 2015 St Vincent Hospital Environment of Care Plan indicated the hospital complies with OSHA (Occupational Safety and Health Administration) and Life Safety Code regulations. 2. OSHA standards indicated that bench mounted abrasive wheels used for external grinding shall be provided with safety guards and work rests. Safety guards shall be strong enough to withstand the effect of a bursting wheel. Work-rests shall be kept adjusted closely to the wheel with a maximum opening of 1/8" to prevent the work from being jammed between the wheel and the rest, 	S 1118	<p>S1118 Physical Plant- hospital failed to maintain environment in such a manner to ensure safety of patients, staff and visitors.</p> <p>Maintenance Shop-safety guards and work rests</p> <p>Corrective Action(s): On or before April 30, 2015, the grinder in the maintenance was removed from service. A new grinder has been ordered but in the interim other grinders with safety guards and work rests are available for use. Beginning on or before June 4, 2015, all Engineering staff were reeducated regarding the OSHA standards specifically with emphasis on the importance of ensuring that the safety guards and work rests are in place at all times to ensure safety for workers and others within the area. Any requisite staff members who fail to complete the education within the designated time frame will be prohibited from working in their areas until documentation of completion is provided. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work. Additionally, beginning in June 2015, an inventory of the area will be completed on a daily basis to ensure safety guards and work rests are in place.</p> <p>Monitoring: To ensure</p>	07/06/2015

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	<p>which may cause wheel breakage.</p> <p>3. At 12:15 PM on 4/28/2015, the Maintenance Shop was observed with a stand mounted grinding machine with two abrasive wheels which were used for external grinding. The safety guards and work-rests for both wheels were missing from the stand mounted grinding machine.</p> <p>4. At 1:05 PM on 4/28/2014, the Floor Care Equipment room was toured. Inside the door of the room was a wall mounted gravity fed eye wash station obstructed by 2 55-gallon trash cans and other maintenance tools.</p> <p>5. At 1:10 PM on 4/28/2014, staff member #A6 (Director of Facilities) confirmed the housekeeping maintenance tools should not obstruct the eyewash station. The staff member indicated the cement floor in front of the eye wash station had striped markings for employees not to place anything on the floor because it would obstruct easy access to the exit of the room and it would also obstruct the eyewash station.</p> <p>6. At 1:20 PM on 4/28/2014, the receiving dock was observed with a closed gray door leading to the rear of the Boiler room blocked with wooden skids</p>		<p>compliance, beginning in June 2015, St. Vincent Director of Facilities or his designee will initiate a monthly audit of the maintenance shop mounted grinding machines to ensure safety guards and work rests are in place and appropriately adjusted. Any identified gaps will be immediately discussed with the staff member on an individual basis for performance improvement. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of the audit will be communicated through the Environment of Care Committee.</p> <p>Responsible Person(s): Director of Facilities or his designee will be responsible for ensuring that Engineering staff have a clear understanding of how services should be provided in a safe environment and the monitoring of these corrective actions for ensure that the deficiency is corrected and will not recur. Floor care equipment room-</p> <p>Corrective Action(s): On or before April 30,2015, while surveyor was onsite, the two 55 gallon trash cans and other</p>				

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	<p>of assorted supplies. The door was tabled with a sign that stated, "Do Not Block". Emergency shutoff switches on the receiving dock were observed obstructing easy access to the electrical shutoff switches.</p> <p>7. At 1:25 PM on 4/28/2014, staff member #A6 (Director of Facilities) confirmed that the shutoff switches should not be blocked by hazardous waste containers.</p> <p>8. On 4-27-2015 at 2:15 pm in the presence of employees #A7, Director of Safety and #A8, Facility Manager, it was observed in the Cancer Center building radiology area room 1, there was a warmer that contained 3 bottles of Omnipaque contrast media. Review of the label on each bottle, printed by the manufacturer, indicated the upper limit of temperature storage was 30 degrees Celsius. It was also observed, on that date and time, the temperature gauge on the warmer indicated 35 degrees Celsius.</p> <p>9. On the above-stated date and time, review of a document entitled BOEKEL Incubator, Temperature Recording, Warmer Location CT SIM, Month April, Year 2015, indicated the Warmer range 34-38 degrees Celsius. Further review indicated temperature checks for the</p>		<p>maintenance tools obstructing the gravity fed eye wash station were removed to ensure unobstructed access to eye wash station in the case of a chemical exposure. On or before May 1, 2015, a three foot area was taped off around the eye wash station as a visual cue to staff members to not place trash cans, maintenance tools or any other items in the area to ensure eye wash station is easily accessible to staff at all times. Beginning on June 4, 2015, floor care equipment room staff will be reeducated emphasizing why it is critical that eye wash stations remain unobstructed at all times so a staff member could quickly flush his eyes in the event of a chemical exposure. Education will be completed June 4, 2015 with immediate implementation. Any requisite staff members who fail to complete the education within the designated time frame will be prohibited from working in their areas until documentation of completion is provided. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work. Monitoring: To ensure compliance, beginning in June 2015, St. Vincent floor care equipment room staff will initiate a monthly audit of the floor care equipment room to ensure that the eye wash station remains unobstructed and ready for use.</p>	

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	<p>month of April ranged from 35.1 Celsius to 38.2 Celsius.</p> <p>10. On 4-28-2015 at 9:30 am in the presence of employees #A7, #A8, #A12, Quality Consultant, and #A13, facilities Supervisor, it was observed at the Women's Hospital medical gas storage area, there were 6 large nitrogen gas tanks and 4 large carbon dioxide gas tanks that were unsecured by chain or holder.</p> <p>11. Review of a document entitled OPERATOR'S GUIDE for the Zoll M Series defibrillator, indicated to keep a fully charged spare battery pack with the device at all times.</p> <p>12. On 4-28-2015 at 1:40 pm in the presence of employees #A6, ACEO, and #A7, Safety Director, it was observed there was a Zoll M Series defibrillator on a cart in the hall of floor 3 South, Cardiology at the West 86th Street hospital facility. At that same time and date, it was observed there was no spare battery pack with the device, nor on or in the cart.</p> <p>13. Review of a document entitled Code Cart/Defib Safety Check, did not indicate a check for the presence of a fully charged spare battery pack with the</p>		<p>This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of the audit will be communicated through the Environment of Care Committee.</p> <p>Responsible Person(s): Director of Facilities or his designee will be responsible for ensuring that Engineering staff have a clear understanding of how services should be provided in a safe environment and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur.</p> <p>Receiving dock- On or before April 30, 2015, while the surveyor was still on site, the door in the receiving dock area with the sign "Do Not Block" was determined to be a convenience door and not an exit from the boiler room. The sign "Do Not Block" was removed and on the boiler room side a sign was added "Not an Exit". Additionally, items obstructing the emergency electrical shutoff switches on the receiving dock were removed to ensure unobstructed access in the event of an emergency and on or before June 4, 2015 a concrete curb was</p>		

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	<p>device</p> <p>14. In interview, at the above-stated date, time and place, a hospital nurse staff member who worked in that area, indicated not being aware of the location of a spare battery pack with the device.</p>		<p>installed to prevent any items from being placed in front of the shut off switches to maintain proper clearance. Cancer Center- Corrective action(s): On or before June 4, 2015, the Director of Imaging reviewed the Omnipaque contrast media package insert to ensure appropriate temperature range when storing Omnipaque contrast bottles in the warmer. Upon further review, on or before June 4, 2015, the document entitled Boekel incubator form was reviewed and revised to indicate the appropriate temperature range to ensure patient safety. On or before June 4, 2015, an email communication went to Directors and managers of Cancer Center area to ensure communication of appropriate temperature range to staff as well a sign was made to post by warmer as a reminder of revised temperature range. Beginning on or before June 4,2015 staff in the Cancer Center who use the warmer to store Omnipaque contrast media where reeducated as to the appropriate temperature range and why it is important to patient safety to ensure this range is not exceeded. Education was completed on or before June 4, 2015 with immediate implementation. Any requisite staff members who fail to complete the education within the designated time frame will be prohibited from working in their</p>	

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			<p>areas until documentation of completion is provided. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work. Monitoring: To ensure compliance, beginning in June 2015, St. Vincent Cancer Center Imaging manager or her designee will initiate a monthly audit of the revised temperature warmer log sheets to ensure that Omnipaque contrast media is stored at the temperature required by manufacturer at all times to ensure patient safety. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of the audit will be communicated through the Quality and Safety Committee.</p> <p>Responsible Person(s): Director of Diagnostic Imaging or her designee will monitor these corrective actions to ensure that the deficiency is corrected and will not recur. Women's medical gas storage area- Corrective Action(s): On or before April 30, 2015, while the surveyor was still</p>	

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			<p>on site, the 6 large nitrogen gas tanks and 4 large carbon dioxide gas tanks were immediately secured by chain or holder to ensure safety of persons and property. Beginning on or before June 4, 2015, a sign was posted in the medical gas storage room to remind staff and vendors how to properly secure tanks upon delivery to room to protect people and property from an explosion.</p> <p>Monitoring: To ensure compliance, beginning in June 2015, Engineering staff will initiate a daily audit of the women's medical gas storage area to ensure (Monday- Friday days of vendor delivery of medical gas) that medical gas tanks are appropriately secured by chain or holder per organizational policy and procedure. Any identified gaps will be immediately discussed with the vendor on an individual basis for performance improvement. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of the audit will be communicated through the Environment of Care Committee.</p> <p>Responsible Person(s):</p>	

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			<p>Director of Facilities or his designee will be responsible for ensuring that Engineering staff has a clear understanding of how services should be provided in a safe environment and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur. 86th Street 3 South Cardiology unit: Zoll M Series Defibrillator: presence of fully charged spare battery with device at all times</p> <p>Corrective Action (s): On July 6, 2015, the Code Cart/Defibrillator Safety Checklist for 3 South Cardiology Unit was reviewed and revised to include a box that indicates: check for presence of fully charged spare battery back with device when Zoll M Series or R Series defibrillator (until time Operator Manual is revised to remove this language) is on cart. Additionally, on July 6, 2015, a fully charged spare battery was placed with the M Series Zoll defibrillator on the cart on the 3 South Cardiology unit in 86th street facility per Operator Manual instructions. Beginning on July 6, 2015, 3 South Nursing Staff were educated regarding the importance of checking for the presence of a fully charged back up battery back on each Zoll M Series or R Series defibrillator when checking code cart for other items per policy. Documentation of education will be maintained.</p> <p>Monitoring: To ensure</p>	

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S 1172 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)		<p>compliance, beginning on July 6, 2015, the 3 South Nursing manager or her designee will initiate a daily audit of the 3 South Code Cart, specifically the Zoll M Series and R Series defibrillator to ensure the presence of a fully charged back up battery is with the device. Any identified gaps will be immediately discussed with the nurse on an individual basis for performance improvement. This audit will be completed for a 3 month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of the audit will be communicated through the 3 South Quality monitoring process.</p> <p>Responsible Person(s): The Director of Cardiology Patient Care Services or her designee will be responsible for ensuring that 3 South Cardiology Nursing staff has a clear understanding of how services should be provided to 3 South patients and monitoring of these corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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	<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 policy and procedure review, observation, facility administrative document review and interview, the facility failed to ensure environmental services were provided at the Stress Center, Women's Hospital and 86th Street hospital in a manner that ensured the prevention of transmission of disease to staff and patients</p> <p>Findings included:</p> <p>1. Review of Environmental Services documents indicated housekeeping employees are expected to do the following daily:</p> <p>General office, Nurse station and Unit cleaning includes:</p>	S 1172	<p>S1172 Physical Plant-failed to ensure environmental services were provided at the Stress Center, Women's Hospital, and 86th Street in a manner that ensure prevention of transmission of disease to staff and patients.</p> <p>Stress Center- 2nd floor Adult Unit Corrective Action(s): St. Vincent Health EVS leadership reviewed its policies and procedures to ensure they appropriately identified the required standards of practice. Education was completed on or before June 4, 2015 with immediate implementation into practice. Specifically, staff received daily and discharge room cleaning re-education with special emphasis on the following items to ensure staff and patients have a clean and safe environment: 1) a room is not</p>	06/04/2015

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	<p>1. Empty wastebaskets, damp wipe and reline</p> <p>2. Dust ledges and door frames</p> <p>3. Dust cleaned desk and counter tops</p> <p>4. Clean spots on doors, door frames, cabinets and glass</p> <p>5. Dust mop and damp mop floor (including corners, edges, behind doors and baseboards) or vacuum</p> <p>Discharge cleaning in patient rooms includes:</p> <p>6. Clean bedside table. Clean drawers and storage cabinet, then wipe front, sides and backs of cabinet and wheels.</p> <p>2. During the tour of the 2nd floor Adult Unit in the Stress Center at 11:40 AM on 04/27/15, accompanied by staff members A10, the Nurse Manager, S18, the Director of the Center, and S19, the Patient Experience Liaison, an empty, but ready for occupancy, patient room was visited. A thick layer of dust was observed on the shelves and both desks in room 17. Trash was in the trash can and toilet tissue was in the commode in the patient bathroom.</p> <p>3. Staff member A10 confirmed the room was designated as ready for a new admission when needed.</p> <p>4. At 11:50 AM on 04/27/15, staff</p>		<p>ready for patient occupancy until the dust has been cleaned from both the shelves and desks, 2) trash in the trash can has been removed and 3) the patient bathroom has been cleaned included the commode is free from toilet paper. Any requisite staff members who fail to complete the education within the designated timeframe will be prohibited from working with Stress Center patients until documentation of completion is provided. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work. Documentation of education will be maintained. Monitoring: To ensure compliance, beginning June 2015, St. Vincent EVS staff leadership or his designee conducts weekly Quality Assurance Cleaning audits at the Stress Center on the 2nd Floor Adult Unit to ensure cleanliness of discharged patient rooms and that room is clean and safe for next patient's stay. Any identified gaps will be reviewed will immediately be discussed with appropriate staff member on an individual basis for performance improvement. These weekly Quality Assurance Cleaning audits will be completed for a 3-month period with expectations for achievement of 90% or greater compliance. If this</p>	

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NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260		
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	<p>member S20, the housekeeper on the unit, was interviewed. He/she confirmed the room had not been completely terminally cleaned after the last patient was discharged. He/she indicated all of the rooms, including the unoccupied patient rooms, should be cleaned, dusted, and mopped daily.</p> <p>5. While touring the Women's Hospital on 4/28/2015, from 0930 hours to 1530 hours, the following conditions were observed:</p> <p>a. At 1145 hours, on the high-risk obstetrics unit, the ultrasound machine and its computer component appeared soiled and the desk-top was dusty. In addition, cleaned patient rooms 247 and 238 had dust on bedside patient storage areas.</p> <p>b. At 1300 hours, on the non-cesarean section inpatient obstetrics unit, in the clean storage area, it was observed that the floor was dusty and had debris on it and the epidural infusion pump was not clean (had dust in brownish substance on it). On the same unit, it was observed that the top of the code cart was dusty.</p> <p>c. At 1400 hours, on the mother and babies obstetrics unit, the clean utility room had dust on storage shelves and the floor appeared dusty and soiled.</p> <p>d. At 1445 hours, in the Newborn</p>		<p>threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of audits will be communicated through the EVS quality monitoring process.</p> <p>Responsible Person(s): Director of EVS or his designee will be responsible for ensuring that staff has a clear understanding of what and how services are provided to St. Vincent Stress Center patients and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur. Women's Hospital: High Risk Unit: St. Vincent Health EVS leadership reviewed its policies and procedures to ensure they appropriately identified the required standards of practice. Education was completed on or before June 4, 2015 with immediate implementation into practice. Specifically, staff received daily and discharge room cleaning re-education with special emphasis on the following items to ensure staff and patients have a clean and safe environment: 1) ultra sound machine and computer component should be clean and not soiled, 2) desk-tops should be free of dust, 3) patient beside storage areas should be dust free</p>		

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	<p>Intensive Care Unit, it was observed that two isolation carts' tops were dusty. In addition, the medicine room, containing the pyxis (medication dispensing device) had dust on shelves, as well as on the pyxis machine itself.</p> <p>6. Hospital staff members #N12 and #N23 concurred with these findings.</p> <p>7. While touring the 86th Street hospital on 4/28/2015 between 0930 hours and 1300 hours, the following conditions were observed:</p> <p>a. At 0930 hours, in the clean storage area of the PCCU (Progressive Coronary Care Unit), there was dust and many empty, dusty linen bags lying on the floor. The linens in the linen cart were not covered. The top of the linen cart and the floor were dusty.</p> <p>b. At 1030 hours on the CVU ("PACU"), in the pantry area, it was noted that the refrigerator had spilled substance on two shelves, as well as spilled orange substance in the door plastic molding. There was brownish spots on the interior walls of the microwave oven, and the turntable was sticky. The clean storage area had bins containing sterile supplies that were dusty and appeared to have specks of unknown substance in them.</p> <p>8. Hospital staff member #N17</p>		<p>before the room is ready for the next patient. Non-cesarean section inpatient obstetrics unit St. Vincent Health EVS leadership reviewed its policies and procedures to ensure they appropriately identified the required standards of practice. Education was completed on or before June 4, 2015 with immediate implementation into practice. Specifically, staff received daily unit cleaning re-education with special emphasis on the following items to ensure staff and patients have a clean and safe environment: 1) clean storage area should be free of dust and debris, 2) epidural infusion pumps surfaces should be clean and soil free, and 3) the top of the code carts should be free of dust. Mother Baby Obstetric unit St. Vincent Health EVS leadership reviewed its policies and procedures to ensure they appropriately identified the required standards of practice. Education was completed on or before June 4, 2015 with immediate implementation into practice. Specifically, staff received daily unit cleaning re-education with special emphasis on the following items to ensure staff and patients have a clean and safe environment: 1) clean utility storage shelves should be free from dust and 2) floor clean with no dust or soiling. Newborn Intensive Care unit St. Vincent Health EVS leadership</p>				

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	<p>concurred with these findings</p> <p>9. On 4/29/2015, staff member #A1, Executive Director of Quality, presented cleaning schedules with specific cleaning duties for the above units. All schedules indicated that the soiled areas mentioned above were on the schedules to be cleaned daily.</p> <p>10. Review of policy and procedure, "Patient Unit Refrigeration Units" policy ID 345248, last reviewed 11/13, indicated:</p> <p>a. Under "Procedure - C. Cleaning", it reads, "At St. Vincent 86th Street the unit refrigerators are wiped inside and out by Food & Nutrition Services associates using an approved sanitizing agent."</p> <p>11. At 1430 hours on 4/28/15, staff # 26 (Director of Environmental Services) indicated that Nutrition and Dietetics cleans the interior of the unit refrigerators.</p> <p>12. Review of the Host/Hostess "stocker shadow report" indicated under "Procedure, Stocker makes sure kitchen on unit is clean and organized".</p> <p>13. On 4.27/15 at 1100 hours, accompanied by staff #24, the Pediatric Emergency Room was toured. The nourishment center microwave had food</p>		<p>reviewed its policies and procedures to ensure they appropriately identified the required standards of practice. Education was completed on or before June 4, 2015 with immediate implementation into practice. Specifically, staff received daily unit cleaning re-education with special emphasis on the following items to ensure staff and patients have a clean and safe environment:1) isolation cart tops should be clean , i.e. free of dust, 2) medication room shelves and pyxis machine should be clean and dust free.</p> <p>Monitoring: To ensure compliance, beginning June 2015, St. Vincent EVS staff leadership or his designee conducts weekly Quality Assurance Cleaning audits at Women's Hospital on the above mentioned units to ensure cleanliness of patient and unit rooms so that rooms are clean and safe for use. Any identified gaps will be reviewed will immediately be discussed with appropriate staff member on an individual basis for performance improvement. These weekly Quality Assurance Cleaning audits will be completed for a 3-month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met,</p>				

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	<p>debris on all interior surfaces.</p> <p>14. On 4/27/15 at 1130 hours, accompanied by staff #24, the Pediatric Intensive Care Unit was toured. The nourishment center refrigerator had spilled food dried on the shelves. The drawers containing patient snacks had dust and debris inside the drawers.</p> <p>15. On 4/27/15 at 1345 hours, accompanied by staff #24 the Adult Intensive Care Unit was toured. The nourishment center microwave had food debris on all interior surfaces. The drawers containing patient snacks had dust and debris inside the drawers.</p>		<p>then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of audits will be communicated through the EVS quality monitoring process.</p> <p>Responsible Person(s): Director of EVS or his designee will be responsible for ensuring that staff has a clear understanding of what and how services are provided to St. Vincent Women Hospital patients and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur. St. Vincent Hospital 86TH Street- Progressive Coronary Care Unit- St. Vincent Health EVS leadership reviewed its policies and procedures to ensure they appropriately identified the required standards of practice. Education was completed on or before June 4, 2015 with immediate implementation into practice. Specifically, staff received daily unit cleaning re-education with special emphasis on the following items to ensure staff and patients have a clean and safe environment: 1) clean storage areas should be dust free 2) free of dusty linen bags lying on the floor, 3) linen cart should be covered, 4) top of linen cart should be dust free, and 5) clean room floor should be dust free. Monitoring: To ensure compliance, beginning June 2015, St. Vincent EVS staff</p>	

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			<p>leadership or his designee conducts weekly Quality Assurance Cleaning audits at St. Vincent 86th street on the above mentioned unit to ensure cleanliness of patient and unit rooms so that rooms are clean and safe for use. Any identified gaps will be reviewed will immediately be discussed with appropriate staff member on an individual basis for performance improvement. These weekly Quality Assurance Cleaning audits will be completed for a 3-month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of audits will be communicated through the EVS quality monitoring process.</p> <p>Responsible Person (s): Director of EVS or his designee will be responsible for ensuring that staff has a clear understanding of what and how services are provided to St. Vincent 86th street patients and guests and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur. CVU- PACU-, Pediatric ER, Pediatric Intensive Care Unit, Adult</p>	

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			<p>Intensive Care Unit- St. Vincent Health EVS leadership and Dietary Services Leadership reviewed its policies and procedures to ensure they appropriately identified the required standards of practice. Education was completed on or before June 4, 2015 with immediate implementation into practice. Specifically, staff received daily unit cleaning re-education with special emphasis on the following items to ensure staff and patients have a clean and safe environment: 1) refrigerator shelves should be clean and free of spills (Nutrition and Dietary Services will be responsible), microwave oven walls and turn tables should be clean and free of spills and sticky substances (EVS will be responsible), 3) clean storage area bins should be free of dust (Supply Chain Services and EVS will be responsible), 4) drawers containing patient snacks in nourishment centers should be free of dust and debri (Nutrition and Dietary Services will be responsible). Monitoring: To ensure compliance, beginning June 2015, St. Vincent EVS staff and Nutrition and Dietary staff conduct weekly Quality Assurance Cleaning audits at St. Vincent 86th street on the above mentioned units to ensure cleanliness of the following areas: 1) refrigerator shelves, 2) microwave oven walls and turn</p>	

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			<p>tables, 3) clean storage area bins, and drawers containing patient snacks in the nourishment centers. Any identified gaps will be reviewed will immediately be discussed with appropriate staff member on an individual basis for performance improvement. These weekly Quality Assurance Cleaning audits will be completed for a 3-month period with expectations for achievement of 90% or greater compliance. If this threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3-month period reflects the achievement of the threshold. Results of audits will be communicated through the EVS and Nutrition and Dietary quality monitoring process.</p> <p>Responsible Person (s): Director of EVS or his designee and the Director Nutrition and Dietary Services or his designee will be responsible for ensuring that staff has a clear understanding of what and how services are provided to St. Vincent 86th street patients and guests and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur.</p>	