

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150150	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2014
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 9/22/2014 through 9/24/2014</p> <p>Facility Number: 002408</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Linda Plummer, RN PH Nurse Surveyor</p> <p>QA: claughlin 10/03/14</p>	S000000		
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</p>			

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>the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and staff interview, the hospital failed to ensure the hospital license was conspicuously posted for patient and public viewing at the 3 offsites: Sleep Center, Ambulatory Surgery and Center for Breast Health.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>At 11:22 AM on 9/23/2014, the offsite Ambulatory Surgery Center was observed without a copy of the Indiana State Hospital License posted at the entrance or in the lobby of the building for the patients and visitors to view.</li> <li>At 11:32 AM on 9/23/2014, the offsite Center for Breast Health was observed without a copy of the Indiana State Hospital License posted at the entrance or in the lobby of the building for the patients and visitors to view.</li> </ol>	S000178	<p><b>S 178 POSTING OF LICENSE</b></p> <ol style="list-style-type: none"> <li>How are you going to correct the deficiency? <ul style="list-style-type: none"> <li>The Indiana State Hospital License was posted, by support services, at the Ambulatory Surgery Center for patients and visitors to view.</li> <li>The Indiana State Hospital License was posted, by support services, at the Center for Breast Health for patients and visitors to view</li> <li>The Indiana State Hospital License was posted, by support services, at the Offsite Sleep Center for patients and visitors to view.</li> </ul> </li> <li>How are you going to prevent the deficiency from recurring in the future? <ul style="list-style-type: none"> <li>Ensuring that the State Hospital License is in place has been added to the Environment of Care Rounds for Ambulatory Surgery Center, Center for Breast Health,</li> </ul> </li> </ol>	09/24/2014

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S000406	<p>3. At 9:15 AM on 9/24/2014, the offsite Sleep Center was observed without a copy of the Indiana State Hospital License posted at the entrance or in the lobby of the building for the patients and visitors to view.</p> <p>4. At 10:32 AM on 9/24/2014, staff member #7, hospital administrator, confirmed the offsites do not have a copy of the hospital license conspicuously posted for patient and public viewing.</p> <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>and Sleep Center.</p> <ul style="list-style-type: none"> <li>· Results of Environment of Care Rounds will be reported through the Environment of Care Committee on a monthly basis. The environment of care committee will make recommendations for follow-up as needed.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Support Services Team Leader</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 9/24/2014</li> </ul>	

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	<p>(1) All services, including services furnished by a contractor. Based on document review and staff interview, the facility failed to ensure the contracted housekeeping service was part of the hospital's comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The 2014 Quality Assessment and Performance Improvement Plan indicated all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</li> <li>The contracted service's contract with Dupont Hospital indicated quality control will consist of regular inspection of work and supervision of staff.</li> <li>Review of the facility's Performance Improvement dashboards and department</li> </ol>	S000406	<p><b><u>S 406 QUALITY ASSESSMENT AND IMPROVEMENT</u></b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>Two quality monitors have been identified and implemented to evaluate the performance of contracted environmental services.</li> <li>These were added to the Environmental Services Quality Report Card and will be reported quarterly through the Operational Performance Team:</li> <li>Quality Monitor #1 The contracted Environmental Services completion of a daily cleaning log will be tracked and reported.</li> <li>Quality Monitor #2 Routine inspection of environments cleaned by the contracted service, and documenting whether or not such environments were cleaned to Dupont Hospital's standards will be done daily by the Environmental Services Team Leader.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p>	10/14/2014	

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	<p>monitors indicated the housekeeping contracted service that provides the housekeeping services for the Sleep Center, Ambulatory Surgery and Center for Breast Health were not monitored by the hospital's quality assessment and improvement (QA&amp;I) program.</p> <p>4. At 2:05 PM on 9/23/2014, staff member #6, Quality Control Manager, confirmed the contracted housekeeping company has not been monitored or evaluated for quality performance. The staff member indicated the hospital does not have inspection logs of work performed by the contracted housekeeping service for the Sleep Center, Ambulatory Surgery, and Center for Breast Health as defined in the contract for quality control. The staff member confirmed the contractor performed housekeeping services for the three offsites since April of 2013.</p>		<ul style="list-style-type: none"> <li>· The Environmental Service Team Leader has begun daily random audits of areas cleaned by the contracted environmental service team.</li> <li>· Results of these audits will be reported up through the Operational Performance Team on a quarterly basis until compliance is maintained and through the Infection Control Committee when applicable.</li> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> <li>· Once a year, a list of current contracted services will be reviewed and compared to a list of contracted services with existing quality monitors. Those without quality monitors will have two or more quality monitors put in place with annual approval by MEC and the Board, which is part of the process to determine whether or not a contract is renewed.</li> <li>· Expectations of performance will be included in a memorandum to all contracted services that have approved quality monitors.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Chief Quality Officer</li> </ul>	

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and staff interview, the facility failed to ensure clean supplies and medication were protected from possible contamination in the Pharmacy Department.</p> <p>Findings included:</p> <p>1. During the tour of the Pharmacy storage room at 2:05 PM on 9/22/2014, accompanied by staff member #9, Facility Director, several cardboard shipping boxes of supplies and gallon container of a cleaning chemical were observed stored in the clean supply room alongside unprotected clean</p>	S000554	<p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/14/2014</li> </ul> <p><b>S554 INFECTION CONTROL</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· On 10/13/2014 pharmacy staff were educated by the pharmacy team leader and the pharmacy specialist on the need to remove cardboard shipping boxes from the pharmacy department.</li> <li>· On 10/21/2014 all cardboard boxes had been removed from the pharmacy department and replaced with plastic bins.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· A daily log was initiated in the pharmacy. The daily log is to be</li> </ul>	10/21/2014

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	<p>equipment and directly above clean supplies and medications on chrome wire storage shelves. The shipping boxes evidenced shipping labels. The unprotected pharmacy supplies included: potassium chloride IV solution, assorted multi-dose medication vials, etc.</p> <p>2. At 2:10 PM on 9/22/2014, staff member #9 confirmed some of the boxes arrived directly to the room from the outside and were not boxes removed from an outer wrap.</p>		<p>updated each shift and specifies that all cardboard boxes have been removed by the end of the shift.</p> <ul style="list-style-type: none"> <li>· Compliance with maintain the daily log will be reported to through the Operational Performance Team committee on quarterly basis until compliance is maintained.</li> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> <li>· One-on-one counseling and remediation will occur as needed with staff who are noncompliant with removing cardboard boxes from the department or maintaining the daily log. This will occur between the staff member and either the team specialist or the team leader.</li> <li>· New Pharmacy team members will receive instruction on maintaining the daily log and removing cardboard boxes from the department, during orientation.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Pharmacy Team Leader</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/21/2014</li> </ul>		

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S000570	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on document review and interview, the infection control committee failed to ensure that required members of the committee attended quarterly meetings for 4 of 5 meetings reviewed.</p> <p>Findings: 1. Review of the "2014 Infection Control Plan" indicated: a. On page 4, under section D.</p>	S000570	<p><u>S 570 INFECTION CONTROL</u></p> <p>1. How are you going to correct the deficiency?</p> <p>The Infection Control Coordinator revised the "2014 Infection Control Plan" to follow State Standard 410 IAC 15-1.5-2 (f)(1)(A)(B)(C) (D)(E) to read, on page 4 under section D., "The Infection Control Committee is</p>	10/21/2014
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	<p>"Infection Control Committee", it reads: "...The Infection Control Committee is interdisciplinary and consists of representatives from Medical Staff, Administration, Infection Control Services, Quality and Risk Management, Nursing..., Environmental Services, and others as needed when discussing particular areas/issues...".</p> <p>2. Review of the Infection Control Committee meeting minutes for 8/28/13, 11/13/13, 2/12/14, 5/14/14, and 8/14/14 indicated that the Environmental Services Director was absent at all of the meetings except on 5/14/14.</p> <p>3. At 9:40 AM on 9/24/14, interview with staff member #60, the infection control practitioner, indicated: a. The Infection Control Plan lists several disciplines as required members of the infection control committee. b. The Environmental Services Director was absent at 4 out of 5 of the last Infection Control Committee meetings, when they are required to attend, per the Infection Control Plan as currently written (and noted in 1. above).</p>		<p>interdisciplinary and consists of representatives from, Medical Staff, Administration, Infection Control Services, Nursing, and other areas as needed when discussing particular areas/issues....."</p> <ul style="list-style-type: none"> <li>· The revisions to the "2014 Infection Control Plan" were presented to and approved by the Infection Control Committee during an e-meeting.</li> <li>· The Environmental Services Team Leader will attend at least 75% of the Infection Control Committee meetings within one calendar year. If he is unable to attend, he will select a representative from Environmental Services to attend in his place.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· The infection control coordinator will send out an email educating members of the committee that 75% is the minimum required attendance during each calendar year.</li> <li>· The infection control coordinator will take attendance at each meeting, with the exception of the e-meeting, by collecting signatures of attendees.</li> <li>· Attendance compliance will</li> </ul>	

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S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(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>(i) Sanitation. Based on policy and procedure review,</p>	S000592	<p>be reviewed at the Infection Control Meeting on a quarterly basis.</p> <ul style="list-style-type: none"> <li>· The committee members that do not attend the minimum required meetings in a calendar will receive counseling on an as needed basis.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Infection Control Coordinator</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>• 10/21/2014</li> </ul>	10/21/2014	

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	<p>document review, observation, and interview, the infection control committee failed to ensure sanitation and cleanliness in several areas toured; failed to approve and recommend changes to housekeeping/environmental services policies related to cleaning/infection control; failed to document follow up at future meetings on issues brought to the committee; and failed to monitor contracted housekeeping staff at off sites.</p> <p>Findings:</p> <p>1. Review of the policy "Patient Care - General Patient Care Warming Devices", no policy number, last revised 11/09, indicated:</p> <p>a. The policy addresses preventive maintenance of the blanket warmers, but does not address cleaning the equipment.</p> <p>2. At 11:45 AM on 9/23/14, while on tour of the off site ASC (ambulatory surgery center) in the company of staff members #52, the CNO (chief nursing officer), and #58, the ASC manager, it was observed in the recovery area that the AMSCO blanket warmer had an extreme amount of built up dust/dust bunnies under the plenum shelf of the upper cabinet of the warmer.</p> <p>3. Interview with staff members #52 and #58 at 11:45 AM on 9/23/14 indicated:</p>		<p><b>S 592 INFECTION CONTROL</b></p> <p><b>Blanket Warmer</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· Verbiage has been added to the "Patient Care-General Patient Care Warming Devices" policy stating that it should be each department's responsibility to ensure that the inside of the blanket warmers are cleaned monthly and as needed.</li> <li>· Notification of the new policy changes for cleaning of the blanket warmer, was sent out to team leaders and specialists on 10/21/2014.</li> <li>· Team Leaders and Specialists educated their team on the updated blanket warmer policy.</li> <li>· The Infection Control Committee reviewed and approved the update to this policy during the e-meeting on 10/21/2014.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· Blanket warmer cleaning has been added to Ambulatory Surgery's departmental weekly cleaning list.</li> </ul>	

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	<p>a. The large amount of dust present in the warmer was both an infection control problem as well as being a fire hazard.</p> <p>b. It was thought that maintenance staff cleaned the warmer when completing preventive maintenance checks.</p> <p>4. Interview with staff member #52, the CNO, at 11:45 AM on 9/24/14 indicated:</p> <p>a. After a phone call with the maintenance manager, it was stated that preventive maintenance was done on 7/1/14 for the AMSCO blanket warmer in the off site ASC recovery area.</p> <p>b. If maintenance cleaned dust from the blanket warmer on 7/1/14, the warmer is accumulating enough dust that it needs cleaning more often, or if cleaning did not occur, this needs to be added to the preventive maintenance policy and checklist to maintain a sanitary environment in the recovery area.</p> <p>5. Review of the policy "Environmental Services Cleaning OR (operating room), Endoscopy and C-Section", ENV 810-63, last reviewed 9/14, indicated:</p> <p>a. Under "Procedure", it reads: "Operating rooms, in which procedures have been performed, are cleaned daily and terminal cleaning is done weekly or upon request...".</p> <p>b. Under "Procedure", it reads: "...3.</p>		<ul style="list-style-type: none"> <li>· The Ambulatory Surgery Specialist will regularly inspect the blanket warmer and review the cleaning list to ensure compliance</li> <li>· The ambulatory surgery specialist will do one-on-one counseling and remediation as needed with employees who are noncompliant with weekly cleaning of the blanket warmer.</li> <li>· All new Ambulatory Surgery team members will be educated on the cleaning of blanket warmers during their department orientation.</li> <li>· Compliance with cleaning of the blanket warmer on a weekly basis will be reported through the Operational Performance Team on a quarterly basis until compliance is maintained.</li> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Ambulatory Surgery Specialist</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/14/2014</li> </ul>	

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	<p>Disinfectant solution is used to clean equipment and areas that should include, but not limited to:...all furniture and equipment...ventilation faceplates...".</p> <p>6. At 11:45 AM on 9/23/14 while on tour of the off site ASC in the company of staff members #52, the CNO, and #58, the ASC manager, it was observed in pain room #6 that the C arm (OEC 9900) had dust, and one hair, around the physicists yellow 3 x 5 card on a ledge of the equipment.</p> <p>7. Interview with staff member #58 at 11:45 AM on 9/23/14 indicated:</p> <p>a. It was agreed that there was a large amount of dust, and a hair, on the C arm in the area stated in 6. above.</p> <p>b. Nursing staff are not to handle the C arms.</p> <p>c. It was thought that radiology staff wiped down the C arms.</p> <p>8. At 10:00 AM on 9/23/14, while on tour of the surgery area in the company of staff member #65, the OR manager, it was observed that:</p> <p>a. In OR suite #11 there was a large amount of dust on the air vents/faceplates on the walls.</p> <p>b. In the soiled utility room (next to the housekeeping closet) there was a large amount of dust on the two ceiling</p>		<p><b>Environmental Services Cleaning OR, Endoscopy, and C-section Policy</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· The Environmental Services Cleaning OR (operating room), Endoscopy and C-Section Policy was revised to include verbiage from the Association of Perioperative Registered Nurses (AORN).</li> <li>· This policy change reflects the current practice that all surgical areas are terminally cleaned daily when in use.</li> <li>· In addition, they are terminally cleaned weekly when not in use and when requested.</li> <li>· The changes to the policy, described above, were reviewed and approved during the Infection Control Committee e-meeting.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <p>100% of environmental staff members signed off on education provided to them on expectation of cleaning a room, and of completing a terminal clean of an OR suite.</p> <ul style="list-style-type: none"> <li>· 100% of the environmental service staff completed a cleaning</li> </ul>	

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	<p>vents/faceplates and there was a dust mop with accumulated dust on the mop head, and on the two brackets that the dust mop was hung on.</p> <p>9. Interview with staff member #64, the EVS (environmental services manager), at 10:10 AM on 9/23/14 indicated:</p> <p>a. It was agreed that the ceiling vents in the soiled utility room had not been cleaned recently.</p> <p>b. The dust mop was extremely dirty</p> <p>c. It was unknown why there was a dust mop in the room, and the last time it had been used, or what for.</p> <p>10. At 10:35 AM on 9/23/14, while on tour of the recovery area in the company of staff member #66, the pre/post manager, it was observed that in bay #8, the tops of the wall mounted regulators were dusty.</p> <p>11. At 10:55 AM on 9/23/14, while on tour of the OB C-Section surgery suite #2, in the company of staff member #55, the labor and delivery manager, it was observed that the wall ventilation faceplate was extremely dusty.</p> <p>12. Interview at 11 AM on 9/23/14 with staff member #55 indicated:</p> <p>a. It was thought that the last C-Section was just 3 days ago and the room should</p>		<p>competency and were observed using proper cleaning technique by the Environmental Services Team Leader.</p> <ul style="list-style-type: none"> <li>· All EVS staff members have been given a checklist for the cleaning a room and for terminally cleaning an OR suite.</li> <li>· Each team member completes a checklist with each room that is cleaned and returns it to the EVS Team leader.</li> <li>· The EVS team leader completes random inspections of his teams work.</li> <li>· The team leader provides counseling and/or remediation to staff members as needed based on findings during inspections.</li> <li>· Cleaning expectations along with the cleaning checklist will be reviewed with each new hire in environmental services during department orientation.</li> <li>· Compliance with cleaning vents/faceplates and soiled utility rooms will be reported through the Operational Performance Team on a quarterly basis and to the Infection Control Committee as needed.</li> <li>· The Operational Performance Team will make recommendations</li> </ul>				

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	<p>have been terminally cleaned and ready for the next patient.</p> <p>b. There was too much dust on the faceplate to have been cleaned 3 days ago.</p> <p>13. Review of the policy "Environmental Services Patient Room Discharge/Transfer Cleaning", ENV 810-41, last reviewed/revised 3/14, indicated:</p> <p>a. Under "Responsibility", it reads: "It is the responsibility of the Environmental Services Department to provide a clean, safe and attractive environment for patients, visitors and staff."</p> <p>b. Under "Procedure", it reads in section 3., "High Dusting:" "Using a specially designed tool and dust cloth, dust all surfaces and fixtures in the room and bathroom above shoulder height. Start at the entrance and proceed clockwise around the room."</p> <p>c. Under "Procedure", it reads in section 4., "Disinfect &amp; Spot Clean:" "Using spray bottle or hand bucket with disinfectant soaked cloth, clean all spots and hand contact areas...ledges...".</p> <p>14. At 2:55 PM on 9/22/14, while on tour of the labor and delivery area in the company of staff members #53, the birthplace director, and #55, the labor and delivery manager, it was observed in</p>		<p>based on reviewed results.</p> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Environmental Services Team Leader</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/20/2014</li> </ul> <p><b>C-Arm</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· The C arm was cleaned on 10/15/2014.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· The cleaning of C arms was added to the radiology techs daily cleaning list.</li> <li>· The Radiology techs maintain a log indicating whether daily cleaning of the C arms was completed.</li> <li>· Radiology techs were re-educated on cleaning c-arms daily.</li> <li>· Cleaning of the C arm on a</li> </ul>	

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	<p>Triage room #3:</p> <p>a. The glass doors had an accumulation of dust on the ledges of the window panes.</p> <p>b. The overhead (pull down type) light had dust on the top of the light.</p> <p>c. The wall mounted suction canister lid had an accumulation of dust.</p> <p>15. Interview with staff members #53 and #55 at 3:00 PM on 9/22/14 indicated this triage room is utilized "almost every day", so that it is frequently cleaned and there should not have been the accumulated dust that was found on survey, as stated in 14. above.</p> <p>16. At 2:30 PM and 2:35 PM on 9/23/14, while on tour of the ICU (Intensive care unit) in the company of staff member #62, the unit director, it was observed that:</p> <p>a. In patient room #2021, the ledges of the glass door window panels had an accumulation of dust present.</p> <p>b. In the Dialysis storage room (formerly a patient room), the under counter toilet was extremely dirty.</p> <p>17. Interview with staff member #62 at 2:30 PM and 2:35 PM on 9/23/14 indicated:</p> <p>a. Room #2021 is not used as frequently as other rooms in the unit, but</p>		<p>daily basis will be added to the instruction given to new Radiology employees as a part of department orientation.</p> <ul style="list-style-type: none"> <li>· Compliance with maintaining the log and cleaning the C arm will be reported through the Operational Performance Team on a quarterly basis.</li> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> <li>· The Radiology Team Specialist will offer one-on-one counseling and/or remediation as needed with staff members who are not compliant with cleaning the C arms as required.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Radiology Team Specialist</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/15/2014</li> </ul> <p><b>Dust</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· The dust on the air vents/faceplates on the walls in OR suite #11 was cleaned on 09/23/14</li> </ul>	

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	<p>should be cleaned routinely and not have dust present as was found during the survey process.</p> <p>b. The contracted dialysis staff flush waste products in the toilet in their storage room. Clean equipment is also stored in this room so that the staff should clean the toilet after flushing their waste products.</p> <p>18. Interview with staff member #59, the infection preventionist, at 9:25 and 9:45 AM on 9/24/14, indicated:</p> <p>a. The off site contracted cleaning staff at the breast center and ASC are not oriented, monitored, or evaluated by the infection control practitioner, or the infection control committee.</p> <p>b. The infection control committee does not have oversight of environmental services policies that effect infection control practices and processes.</p> <p>c. The infection control committee meeting minutes of 5/14/14 indicated EVS was "going to start using a new disinfectant cleaner Alpha-HP, that will replace our 3M products...".</p> <p>d. There was no approval by the infection control committee related to the change in disinfection product listed in c. above.</p> <p>e. It is unclear that business, documented in various infection control meetings, was followed up on at</p>		<p>prior to completion of the survey.</p> <ul style="list-style-type: none"> <li>· The two ceiling vents/faceplates in the soiled utility room were cleaned on 09/23/14 prior to completion of the survey.</li> <li>· The dust mop was removed from the soiled utility room and disposed of on 09/23/14 prior to the completion of the survey.</li> <li>· The two brackets that the dust mop hung on in the soiled utility room were cleaned on 09/23/14 prior to completion of the survey.</li> <li>· In recovery, the tops of the wall mounted regulators in bay #8 were cleaned on 9/25/2014.</li> <li>· The wall ventilation faceplate in OB C-Section surgery suite #2 was cleaned on 9/25/2014.</li> <li>· Triage Room #3 was thoroughly cleaned per hospital policy and inspected by the EVS Team Leader on 9/26/2014.</li> <li>· Room #2021, located in the ICU was cleaned on 09/27/14.</li> <li>· The toilet in the dialysis cleaning room was cleaned on 10/15/2014 and added to the cleaning schedule.</li> </ul>	

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	<p>meetings following, such as:</p> <p>A. The 8/28/13 meeting minutes indicated that a "New IC (infection control) Grid will implement in January", but no further mention of this can be found in the 2/12/14 or further meeting minutes.</p> <p>B. The 8/28/13 meeting minutes address a PEP (post exposure procedure) that was out dated and that "The new policy will be sent to IC when approved.", with no reference to this in the 2/12/14 or further meeting minutes.</p> <p>f. The 2/12/14 and 5/14/14 meeting minutes read "Old Business: None", indicating that follow up from previous meetings was not discussed.</p>		<p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· 100% of environmental staff members signed off on education provided to them on expectation of cleaning a room, and of completing a terminal clean of an OR suite.</li> <li>· 100% of the environmental service staff completed a cleaning competency and were observed using proper cleaning technique by the Environmental Services Team Leader.</li> <li>· All EVS staff members have been given a checklist for the cleaning a room and for terminally cleaning an OR suite.</li> <li>· Each team member completes a checklist with each room that is cleaned and returns it to the EVS Team leader.</li> <li>· The EVS team leader completes random inspections of his teams work.</li> <li>· The team leader provides counseling and/or remediation to staff members as needed based on findings during inspections.</li> <li>· Cleaning expectations along with the cleaning checklist will be reviewed with each new hire in</li> </ul>		

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			<p>environmental services during department orientation.</p> <ul style="list-style-type: none"> <li>Compliance with cleaning vents/faceplates and soiled utility rooms will be reported through the Operational Performance Team on a quarterly basis and to the Infection Control Committee as needed.</li> <li>The Operational Performance Team will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>Environmental Services Team Leader</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>10/20/2014</li> </ul> <p><b>Contracted Environmental Staff</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>The off site contracted cleaning staff were educated from 10/14/14-10/16/14 on Dupont Hospital's cleaning policy and expectations.</li> <li>Each contracted staff member received a copy of cleaner used at Dupont hospital and a</li> </ul>		

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			<p>checklist of items that were to be cleaned in each area on 10/16/2014.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· 100% of the contracted staff signed off that they had received this education.</li> <li>· The EVS Team Leader will continue to provide education to the contracted cleaning staff as needed and as new staff members join the team.</li> <li>· The EVS Team Leader completes random inspections of the contracted staff members' work.</li> <li>· The team leader provides counseling to contracted staff members as needed based on findings during inspections.</li> <li>· Results of EVS Team Leader rounds will be reported to the company in which services are contracted through.</li> <li>· Cleaning expectations along with the cleaning checklist will be reviewed with each new hire in in the contracted environmental services by the Environment Services Team Leader.</li> <li>· Compliance with cleaning will be reported through the Operational</li> </ul>	

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			<p>Performance Team on a quarterly basis and to the Infection Control Committee as needed.</p> <ul style="list-style-type: none"> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Environmental Services Team Leader</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/20/2014</li> </ul> <p><b>Outstanding IC Committee Items</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· An infection control e-meeting was held on 10/21/14 to close out old items.</li> <li>· The Infection Control Committee approved the use of Alpha-HP cleaner on 10/21/14.</li> <li>· The new IC Grid, initiated in January, was approved by the infection control committee on 11/13/2013.</li> <li>· Follow up on the status of the new policy addressing post exposure</li> </ul>	

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S000608	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)  (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows:		<p>procedure was reviewed in the Infection control e-meeting on 10/21/14.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>An Action Item Log has been created for the Infection Control Committee. Outstanding items discussed at committee will be placed on the log with an owner assigned.</li> <li>The Action Log will be reviewed at every Infection Control Committee meeting to ensure outstanding items are followed up on and discussed in the meetings.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>Infection Control Coordinator is responsible for IC committee action log</li> </ul> <p>4. By what date are you going to have the deficiency corrected? 10/21/2014</p>	

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	<p>(3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(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 and procedure review, observation, and interview, the infection control practitioner failed to ensure that surgical staff followed the facility policy, related to surgical attire, in the off site ASC (ambulatory surgery center).</p> <p>Findings:</p> <p>1. Review of the policy "Patient Care - Surgical Services O.R. (operating room) Dress Code", no policy number, last reviewed 2/13, indicated:</p> <p>a. Under "Action Directives", it reads in section F. "Masks": "...3. Masks will be removed and discarded at the end of each case. 4. Masks will not be left dangling around the neck at any time."</p> <p>2. At 11:37 AM on 9/23/14, while on tour of the off site ASC in the company of staff members #52, the CNO (chief nursing officer), and #58, the ASC manager, it was observed that one surgery staff member (in blue scrubs)</p>	S000608	<p><b><u>S 608 INFECTION CONTROL</u></b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· The team member that was observed with their mask down was re-educated on the O.R. Dress Code Policy.</li> <li>· The policy "Patient Care-Surgical Services O.R. Dress Code," was reviewed and approved at the Infection control e-meeting on 10/21/14.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· The surgical team leader reviewed the policy "Patient Care-Surgical Services O.R. Dress Code," with surgical staff on 10/14/14. Staff were instructed to remove and discard masks at the end of each case. Staff were instructed not to leave masks</li> </ul>	10/21/2014

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	<p>walked through the recovery area (from the OR area) and exited to an outer hallway with a surgical mask down and dangling about the neck.</p> <p>3. Interview with staff members #52 and #58 at 11:40 AM on 9/23/14 indicated facility policy states that masks are not to be worn dangling about the neck.</p>		<p>dangling around the neck at any time.</p> <ul style="list-style-type: none"> <li>· Additional counseling and remediation will occur on an individual and as needed basis between the team specialist or team leader and O.R. Staff when non-compliance with policy is identified.</li> <li>· Noncompliance with the operating room dress code will be monitored for during routine leadership rounds of the ambulatory surgery center.</li> <li>· Results of leadership rounds, along with deficiencies noted in these rounds, will be reported quarterly through the Operational Performance Team.</li> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Ambulatory Surgery Specialist is responsible for dress code compliance</li> </ul> <p>4. By what date are you going to have the deficiency corrected? 10/21/2014</p>	

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NAME OF PROVIDER OR SUPPLIER  DUPONT HOSPITAL LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2520 E DUPONT RD FORT WAYNE, IN 46825			
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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, medical record review and staff interview, the nursing executive failed to ensure the implementation of policies and procedures related to: blood</p>	S000912	<p><u>S 912 NURSING SERVICES</u></p> <p><b>Blood</b></p> <p>1. How are you going to correct the</p>	10/24/2014			

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	<p>administration and restraints for 2 of 2 patients who received blood products (pt. #10 and #11) and 1 of 1 patient with restraints (pt. #10); failed to ensure that nursing staff followed their protocol for signing in and out mother's breast milk in the nursery and NICU (neonatal intensive care unit); and failed to implement facility policy related to two pantry/nutrition refrigerators.</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Patient Care - General Patient Care Blood Administration and Transfusion Reactions", no policy number, effective 4/01, last revised 12/08, indicated:</p> <p>a. Under "Procedure", it reads in section C. "Guest Preparation": "...3. Assess for any pre-transfusion symptoms such as elevated temperature, which could be confused with a transfusion reaction...7. Prepare the infusion site...".</p> <p>b. Under "Procedure", it reads in section E. "Blood Administration": "...7. Assess the guest, including blood pressure, pulse, respirations, and temperature and record as Start Time vital signs...14. Start the infusion at 1 - 2 ml per minute...for the first 15 minutes...".</p> <p>2. Review of patient medical records indicated that pt. #10 had two units of</p>		<p>deficiency?</p> <ul style="list-style-type: none"> <li>· Education on administering blood products was sent out to nurses on 10/17/14. This education included the need to take vitals no later than one hour prior to starting a blood transfusion to serve as baseline vitals. The education also specified that nursing staff need to document their pre-transfusion vitals prior to the initiation of their blood transfusion. Start of the blood transfusion and baseline vitals cannot be charted at the same time.</li> <li>· All nurses signed off on receipt of the education by 10/22/14. All nurses not present during these dates will sign off on the education prior to beginning their next shift.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· The Core Measures Nurse reviews medical records of all patients that receive blood products.</li> <li>· If during blood audits, the core measure nurse notices a deficiency in charting, she notifies the team specialist or team leader who will provide counselling to the nurse responsible for the deficiency as needed.</li> </ul>	

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	<p>blood product administered on 5/25/14 and:</p> <p>a. The vital signs taken at the beginning of administration of the first unit have the time of 5:29 AM and 5:30 AM with the start of the blood noted as being 5:30 AM.</p> <p>b. It is not clear that the vital signs were prior to the start of the blood administration.</p> <p>3. Review of the patient medical record for pt. #11 indicated:</p> <p>a. Vital signs and the start of blood administration was at 3:05 PM on 6/19/14.</p> <p>b. Vital signs were not documented as being taken prior to the start of the infusion.</p> <p>4. At 11:50 AM on 9/24/14, interview with staff members #57, a quality coordinator, and #61, a core team leader, indicated:</p> <p>a. The policy lists assessing the patient's (guest) vital signs first (see 1. a. and b. above) and then begin the blood administration.</p> <p>b. It is unclear that vital signs were taken prior to the beginning of blood administration for patients #10 and #11 as documentation by nursing staff appears that vitals were at the same time that infusion began.</p>		<ul style="list-style-type: none"> <li>· Education on blood transfusion and appropriate documentation will be provided to new nurses during orientation.</li> <li>· Blood audit reports are sent out on a monthly basis to department heads who then share results with their staff.</li> <li>· The blood audit reports are shared and discussed quarterly at the Operational Performance Team meeting.</li> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Chief Nursing Officer</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/24/2014</li> </ul> <p><b>Restraints</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· Education on restraints was sent out to nurses on 10/17/14. This education included the need to assess and chart on patient in restraints in a time frame no longer</li> </ul>	

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	<p>c. The 5:29 AM and 5:30 AM times are confusing in the medical record for pt. #10 as it cannot be determined exactly what documentation goes with which time.</p> <p>d. If vitals were found to be such that blood could not be administered, and the infusion had started while taking vital signs, the unit would have to be disconnected and discarded, making a waste of the unit necessary.</p> <p>5. Review of the policy "Patient care - General Patient Care Restraints", no policy number, effective 4/01 and last revised 7/09, indicated:</p> <p>a. Under "Procedures", in section E., it reads: "...3. a qualified registered nurse must perform and document an assessment at least every 2 hours...".</p> <p>6. Review of the medical record for pt. #10 indicated the patient was admitted at 11 PM on 5/23/14 and had soft wrist restraints applied for the patient's safety so they would not pull at IV (intravenous) and ventilator lines and tubes. Documentation times related to assessing the patient were as follows:</p> <p>a. 11 PM on 5/23/14; 2:21 AM on 5/24/14; 4:28 AM on 5/24/14; 7:16 AM on 5/24/14; 9:20 AM on 5/24/14; 11:40 AM on 5/24/14; 1:50 PM on 5/24/14; 4:05 PM; 6:25 PM; 8:15 PM, 10:07 PM;</p>		<p>than every 2 hours.</p> <ul style="list-style-type: none"> <li>· All nurses signed off on receipt of the education by 10/24/14. All nurses not present during these dates will sign off on the education prior to beginning their next shift.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· The Core Measures Nurse reviews medical records of all patients in restraints</li> <li>· If during restraint audits, the core measure nurse notices a deficiency in charting, she notifies the team specialist or team leader who will provide counselling to the nurse responsible for the deficiency as needed.</li> <li>· Education on restraints and appropriate documentation will be provided to new nurses during orientation.</li> <li>· Results of the restraint audit will be shared and discussed on a monthly basis through the Operational Performance Team.</li> <li>· The Operational Performance</li> </ul>	

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	<p>and 12:03 AM on 5/25/14.</p> <p>b. The time frame between nursing documentation notes for restraint assessment were: 3 hours 21 minutes; 2 hours and 7 minutes; 2 hours and 48 minutes; 2 hours and 4 minutes; 2 hours and 20 minutes; 2 hours and 10 minutes; 2 hours and 15 minutes; 2 hours and 20 minutes; 1 hour and 50 minutes; 1 hour and 52 minutes; and 1 hour and 56 minutes.</p> <p>7. At 12:10 PM on 9/24/14, interview with staff members #57, a quality coordinator, and #61, a core team leader, indicated:</p> <p>a. Nursing failed to document an assessment of the patient while in restraints every two hours, as required by facility policy, for pt. #10, as stated in 6. above.</p> <p>8. At 2:55 PM on 9/22/14, while on tour of the newborn nursery in the company of staff members #56, the NICU manager, and #54, the nursery/post partum manager, it was observed that:</p> <p>a. The freezer with mothers' breast milk had 3 bottles of breast milk dated 9/21/14 and 2 bottles of breast milk (all for the same NICU baby) dated 9/15/14.</p> <p>b. The sign in sheet located in this pantry area lacked the "sign in", logged by two nurses, for the 5 bottles of breast</p>		<p>Team will make recommendations based on reviewed results.</p> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Chief Nursing Officer</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/24/2014</li> </ul> <p><b>Breast Milk</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· A "Breast Milk" policy was created on 10/17/14.</li> <li>· The "Breast Milk" policy details the following process. A sign in and sign out sheet is no longer used. Instead two nurses check, verify, and cosign the label on the breast milk. After the breast milk is given to the patient the cosigned label is added to a breast milk log at the patient's bedside.</li> <li>· The "Breast Milk" algorithm was removed with the implementation of the new policy.</li> <li>· Education on signing in and signing out breast milk was sent out to all nursing staff 10/17/14. This education included the need to have two RNs sign in and sign out breast</li> </ul>	

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	<p>milk found in the freezer.</p> <p>c. The last breast milk signed in to this freezer was on 8/20/14.</p> <p>d. None of the 6 bottles of breast milk (for 4 babies) were counter signed by a second nurse.</p> <p>e. The sign in sheet for the second floor NICU was provided and the five bottles of breast milk in this freezer were not logged in on this form, either.</p> <p>f. 3 of the 7 lines on this form (listed in e. above) lacked a second nurse signature for confirmation of breast milk placed in the freezer.</p> <p>9. Interview with staff members #54 and #56, at 3:05 PM on 9/22/14, indicated:</p> <p>a. It was confirmed that the 5 bottles of breast milk, found in the nursery freezer, were not signed in, as per facility protocol.</p> <p>b. The "Breastmilk Tracking" guidelines were provided and indicated there is to be a "Two RN double check" of breastmilk when taken from the freezer, but there was no sign out sheet in the nursery where the 5 bottles of breast milk (not logged in) were found.</p> <p>c. There are two NICU areas, on different floors, where breast milk is monitored making the sign in and sign out process confusing, especially if the NICU baby is on one floor and the frozen breast milk is on another floor.</p>		<p>milk.</p> <ul style="list-style-type: none"> <li>· Additional education was provided to NICU and Post Partum nurses by their team specialists</li> <li>· All Birthplace nurses signed off on receipt of the education by 10/24/14. All nurses not present during these dates will sign off on the education prior to beginning their next shift.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· The NICU Specialist will monitor the breast milk log for compliance.</li> <li>· Education on the breast milk policy and appropriate procedure will be provided to new Birthplace nurses during orientation.</li> <li>· Compliance with utilization of the breast milk log will be tracked and reported on a quarterly basis through the Operational Performance Team.</li> <li>· The team specialists will provide counseling and remediation as necessary for non-compliance</li> </ul>	

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	<p>d. There is no facility policy related to breast milk, storage, sign in and sign out.</p> <p>e. Nursing staff are not following the written "Breastmilk Tracking" algorithm.</p> <p>10. Review of the policy and procedure "Infection Control Refrigerator Cleaning", no policy number, with an effective date of 4/01 and a reviewed date of 2/13, indicated:</p> <p>a. Under "Procedure", it reads: "A. Unit Food and Nourishment (Guest) Refrigerators...1. All guest refrigerators will be cleaned weekly...b.. Team members will dispose of any expired food/beverage items...".</p> <p>11. At 2:05 PM on 9/22/14, while on tour of the labor and delivery area in the company of staff members #53, the birthplace (obstetrics) director, and #54, the post partum manager, it was observed in the pantry/nourishment refrigerator that 5 half pint containers of milk had expired on 9/21/14.</p> <p>12. Interview with staff members #53 and #54 at 3:00 PM on 9/22/14 indicated:</p> <p>a. It was agreed that the 5 containers of milk had expired the previous day.</p> <p>b. Dietary staff only re stock the refrigerator when the unit calls and requests it.</p> <p>c. The last time dietary staff stocked the</p>		<p>with utilizing the breast milk tracking log.</p> <ul style="list-style-type: none"> <li>The Operational Performance Team will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>Chief Nursing Officer</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>10/24/2014</li> </ul> <p><b>Food Storage</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>The blender bottle was removed from the ICU refrigerator on 9/23/2014.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>All ICU staff members were provided a copy of the policy, "Infection Control Food Storage: Guest and Team Member" on 10/17/14. All ICU staff members were required to sign off on the receipt of this policy by 10/24/14. All nurses not present during these dates will sign off on the education prior to beginning their next</li> </ul>	

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	<p>refrigerator was, most likely, on Friday, 9/19/14, in preparation of the weekend.</p> <p>13. Review of the policy and procedure "Infection Control Food Storage: Guest and Team Member", no policy number, last reviewed 2/13, indicated: a. Under "Procedure", it reads: "...3. Guest's food should be discarded if not labeled or within 48 hours of date if not consumed...".</p> <p>14. At 2:40 PM on 9/23/14, while on tour of the ICU (intensive care unit) in the company of staff member #62, the med/surg/ICU manager, it was observed that one pink "blender bottle", with water, was found in the patient/guest refrigerator and was not labeled and or dated.</p> <p>15. Interview with staff member #62 at 2:45 PM on 9/23/14 indicated: a. It was unknown if the bottle belonged to a patient/guest, or an employee. b. The bottle should not have been in the refrigerator without a label and date.</p>		<p>shift.</p> <ul style="list-style-type: none"> <li>· The ICU Specialist will provide counseling and remediation as necessary for non-compliance with the food storage policy.</li> <li>· Education on the "Food Storage" policy and appropriate procedure will be provided to new ICU employees during orientation.</li> <li>· The ICU Team Specialist will routinely check for unlabeled items during leadership rounds.</li> <li>· The ICU Specialist will provide counseling and remediation as necessary for non-compliance with the food storage policy.</li> <li>· Results of rounds, along with any deficiencies, will be reported quarterly through the Operational Performance Team.</li> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p>		

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on documentation review and observation, the hospital failed to maintain the equipment in such a manner that the safety and well-being of staff are assured in the Maintenance Shop.</p> <p>Findings included:</p> <p>1. The Safety Management Plan Last reviewed and approved 7/2014) indicated the hospital complies with OSHA and Life</p>	S001118	<p>ICU Specialist</p> <p>4. By what date are you going to have the deficiency corrected?</p> <p>10/24/2014</p> <p><u>S 1118 PHYSICAL PLANT</u></p> <p>1. How are you going to correct the deficiency?</p> <p>Work-rests for both wheels were located and replaced for the bench mounted machine with two abrasive wheels, which is used for external grinding, located in the Mechanical Shop on 10/17/2014.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p>	10/17/2014

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	<p>Safety Code regulations and standards.</p> <p>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, which may cause wheel breakage.</p> <p>3. At 1:15 PM on 9/22/2014, the Maintenance Shop was observed with a bench mounted machine with two abrasive wheels which are used for external grinding. The work-rest for both wheels were missing from the bench mounted machine.</p>		<ul style="list-style-type: none"> <li>· Monitoring that safety guards are present on all machinery has been added to the departmental monthly safety round check sheet.</li> <li>· Results of the safety rounds are reported monthly throughout the Environment of Care committee.</li> <li>· The Environment of Care Committee will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Plant Operations Team Leader</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/17/2014</li> </ul>	

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S001164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and staff interview, the facility failed to assure preventive maintenance was conducted on Inpatient Rehab wooden steps and a medication pump.</p> <p>Findings included:</p> <p>1. Dupont Hospital Medical Equipment Management Plan (last reviewed and approved 7/11/2014) indicated that staff are to conduct preventive and continuing maintenance of all patient care equipment.</p>	S001164	<p><b>S 1164 PHYSICAL PLANT</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>· An asset tag was placed on the patient care steps located in the in-patient Rehab Department on 10/06/2014.</li> <li>· All pumps located within Dupont Hospital were checked for preventive maintenance tags indicating that equipment was due or overdue for preventive maintenance on 9/25/2014.</li> <li>· It was found by the Plant Operations Team Leader on</li> </ul>	10/14/2014

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	<p>2. At 2:10 PM on 9/22/2014, the in-patient Rehab Department was observed with wooden patient care rehab steps that had no asset tag on the item.</p> <p>3. Dupont Hospital Service Request Work Order #39314 indicated Asset #DH07671 ALARIS medication pump had its last preventive maintenance performed on 12/7/2012. Work order #42509 for preventive maintenance was generated 12/1/2013. However, the documentation revealed the preventive maintenance was never completed. The medication pump was assigned to receive preventive maintenance on an annual schedule; therefore, the selected medication pump has not had its preventive maintenance inspection for approximately 21 months.</p> <p>4. At 2:00 PM on 9/23/2014, staff member #5, Clinical Engineer, indicated the inpatient rehab steps have never had a written</p>		<p>10/14/14 that the 30 medication pumps that did not receive their annual preventive maintenance are currently shipped out for their preventive maintenance check.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· Since ALARIS pumps may travel to any hospital within the network, when it comes up in the computer system that their preventive maintenance is due and they are not located at Dupont Hospital it will be charted that (a) the pump was removed from service, and (b) The pump could not be located at this time.</li> <li>· The maintenance team looks for preventive maintenance tags that are due or overdue for preventive maintenance routinely with their rounds.</li> <li>· Results of departmental rounding and preventative maintenance is reported monthly through the Environment of Care Committee.</li> <li>· The Environment of Care Committee will make recommendations based on reviewed results.</li> </ul>	

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S001510	<p>preventive maintenance inspection. The staff member indicated the item would be visually checked before use; however, the inspection was never documented. The staff member indicated the hospital has 30 medication pumps throughout the facility that did not receive their annual preventive maintenance.</p> <p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following: (A) Provision for the care of the disturbed patient. (B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care. (C) Provision for transfer of patients</p>		<p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· Plant Operations Team Leader</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/14/2014</li> </ul>	

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	<p>when care is needed which cannot be provided.</p> <p>Based on policy and procedure review, medical record review, and staff interview, the facility failed to follow standards of practice in transferring patients from an inpatient unit, other than the ED (emergency department), to another acute care hospital, for one NICU (neonatal intensive care unit) patient (pt. #11).</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Service Patient Care - Emergency", "Subject Transferring Patients to Another Facility CHS (community health systems) Compliance Policy/Procedure G2B", effective 4/01 and last revised 8/08, indicated:</p> <p>a. Under "Procedure", it reads: "A. Obtain transfer order(s) from all attending and consulting physicians...C. Notify patient, physicians, family, and significant other involved in the time of the transfer. ED physician will complete Authorization for Transfer Form...E. Obtain Consent from patient or appropriate consenting party..."</p> <p>2. Review of the policy and procedure "Service Patient Care - Emergency" 'Subject Screening, Stabilization and Transfer of Individuals with Emergency</p>	S001510	<p><b>S 1510 EMERGENCY SERVICES</b></p> <p>1. How are you going to correct the deficiency?</p> <ul style="list-style-type: none"> <li>Transfer Form Number 1600-0001-219 will be utilized for all patients transferred out of the facility. This form has a section for accompanying documentation that can be filled out by the registered nurse. It also has a section for "patient" or "responsible person's" consent.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>Education on the need to complete the transfer form, obtain consent, and verify that there is a physician order present was sent out to Birthplace, Nursery and NICU nurses on 10/17/14.</li> <li>All Birthplace, Nursery, and NICU nurses signed off on receipt of the education by 10/24/14. All nurses not present during these dates will sign off on the education prior to beginning their next shift.</li> <li>The charge nurse will be</li> </ul>	10/24/2014

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	<p>Medical Conditions CHS Compliance Policy/Procedure G2A", with an effective date of 4/03, last revised 11/12, indicated:</p> <p>a. Under section "II. Definitions", it reads in item I.: ""Transfer" means the movement (including discharge) of an individual outside the Hospital's facilities at the direction of any person employed or associated, directly or indirectly, with the Hospital but does not include the movement of an individual who: (1) is being moved from one location in the Hospital to another location in the Hospital;..."</p> <p>b. Under "Procedures", it reads in section B. 2.: "The appropriate portions of the Transfer Information Form shall be completed if the individual is transferred to another medical facility..."</p> <p>3. Review of the policy and procedure "Service Patient Care - NICU" "Subject Infant Transfer/Transport Documentation", no policy number, last revised 6/08, indicated:</p> <p>a. In section I. "Position/Policy Statement": "A. The following guidelines will be utilized for MICU (medical intensive care unit) runs: 1. Neonatal MICU referrals may be made through: a. Neonatologist/physician b. Neonatal Intensive Care KEYNOTE: THE PHYSICIAN IS RESPONSIBLE</p>		<p>responsible for ensuring that the transfer form is filled out, consent is obtained, and an order is present.</p> <ul style="list-style-type: none"> <li>· If it is found that any of the items is listed above is not present, one-to-one counseling will occur with the nursing staff responsible for the omission.</li> <li>· Education on the need to obtain patient/responsible person's consent upon transfer of a patient will be provided to new Birthplace, NICU, and Nursery nurses during department orientation.</li> <li>· The NICU team specialist will be auditing charts of transfers from the department and reporting the results of this audit monthly through the Operational Performance Team Committee.</li> <li>· The Operational Performance Team will make recommendations based on reviewed results.</li> </ul> <p>3. Who is going to be responsible for above?</p> <ul style="list-style-type: none"> <li>· NICU Specialist</li> </ul> <p>4. By what date are you going to have the deficiency corrected?</p> <ul style="list-style-type: none"> <li>· 10/24/2014</li> </ul>	

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	<p>FOR NOTIFYING THE RECEIVING UNIT OF THE IMPENDING TRANSPORT IF HE/SHE RECEIVES THE INITIAL CALL FOR TRANSPORT. 2. A Maternal/Infant transfer form will be completed for the receiving hospital and will include: a. Maternal antenatal and labor history and physical...B. Infant's Apgars at birth...".</p> <p>b. Under II. "Purpose", it reads: "To provide continuity of patient care during MICU transport." And, in section III. "Rationale", it reads: "Continuity of care of the patient can be maintained by communicating pertinent information."</p> <p>4. Review of the medical record for NICU patient #11 indicated:</p> <p>a. This 5 pound 2 oz patient was born on 6/15/14 and admitted to the NICU for respiratory distress.</p> <p>b. Care was given in the NICU until 7/17/14 when the infant was transferred to another acute care facility for biliary issues.</p> <p>c. No physician order for transfer could be found in the medical record.</p> <p>d. No transfer form could be found for the patient that would indicate: what records were sent for the continuity of patient care, that the physician contacted the receiving unit, that the family was notified and gave permission for the transfer.</p>			

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	<p>5. Interview at 10:50 AM on 9/24/14 with staff member #57, a quality coordinator, indicated:</p> <p>a. After on line review of the medical record for pt. #11:</p> <p>A. No physician order for transfer could be found. (A discharge summary/transfer note was found in the record, but not a physician order.)</p> <p>B. No transfer form was found in the medical record.</p> <p>6. Interview with staff members #53, the birthplace (obstetrics) director, and #56, the NICU manager, at 11:35 AM on 9/24/14 indicated:</p> <p>a. It cannot be determined that risks and benefits of transfer were provided to the parents of the transferred infant, due to lack of documentation .</p> <p>b. It cannot be determined that the parents of pt. #11 gave permission to transfer the patient, due to lack of documentation.</p> <p>c. There is no physician order to transfer the patient.</p> <p>d. The birthplace, nursery, and NICU have no transfer form to be utilized, if needed, for patient transfers.</p> <p>e. Most transfers are within the health network system and staff have access to on line medical record information so that copying chart information would not</p>			

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	<p>be needed.</p> <p>f. The MICU transport team has family sign a consent for transfer by their mobile unit. (The form titled: "[other named] Hospital Critical Care Transport Signature Form" with a number 1600-00010131 revised 12/02/09 "Consent for MICU [other hospital] Air Transport" was provided.)</p> <p>g. A copy of the MICU signed form is not kept in this hospital's patient medical record.</p> <p>7. At 11:50 AM on 9/24/14, interview with staff member #50, the quality director, indicated:</p> <p>a. The policies listed in 1. and 2. above are generally written for the ED and do not state what the inpatient units are to do when they need to transfer a patient to another acute care facility.</p> <p>b. A copy of the facility transfer from "Form Number 1600-0001-219" revised 6/24/08, was provided and it, too, was written more for ED use rather than nursing unit processes of patient transfer,</p>				