AND PLAN OF CO	RRECTION	IDENTIFICATION NUMBER:	A RI	ILDING	00	COMPL	ETED
		CTION IDENTIFICATION NUMBER:		ILDIIIO	00	COMPLETED	
		150149	B. WI	NG		10/07/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVID	DER OR SUPPLIER				ATEWAY BLVD		
WOMEN'S HC	SPITAL THE				JRGH, IN 47630		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S 0000							
Dida 00							
Bldg. 00		C4.4. 1:	0.00	100			ı
		r a State licensure	S 00	100			
sur	survey.						
Dat	tes of survey:	10/5/15 to 10/7/15					
Fac	eility #002855						
ЛС	10/28/15						
	IDR Committee held on 12-30-15; No changes made. JL						
mad	ie. JL						
l I	IAC 15-1.4-2						
l I	ALITY ASSESS	SMENT AND					
	ROVEMENT						
410	IAC 15-1.4-2(a	a)(1)					
(a) -	The hospital sh	all have an					
	-	d, hospital-wide,					
	•	ality assessment and					
imp	rovement progr	ram in which all areas					
	ne hospital part						
		ongoing and have a					
		lementation that					
		ot limited to, the					
TOLIC	owing:						
(1)	All services, inc	cluding services					
	ished by a con						
i i	-	ent review and	S 04	06	Correction of deficiency:		11/20/2015
inte	erview, the qu	ality assessment and			Currently physician report		
		rovement (QAPI)			cards (QI data) are reviewed		
1	•	include anesthesia			and sent to Medical Affairs		
pro.	5-4	morado anobinosta			annually for re-credentialing		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 1 of 15

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150149			A. BUIL B. WING	LDING	00	(X3) DATE (COMPL 10/07/	ETED
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	10/01/	2013
WOMEN	'S HOSPITAL THE		NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
S 0554	Assessment and Improvement Plascope of this plaservices provide assessed at least approved by the 3/3/15. 2. Review of 20 (02/19, 05/14 and there was no document an esthesia serviced A15, Quality Matorices, confirm	e document titled Quality Performance an 2015 indicated the n includes all care and d by the hospital. Data is quarterly. The plan was Board of Managers on 15 quality reports d 08/20/15) indicated cumentation of review of			process. Anesthesia report card process was reviewed with surveyor and Anesthesi reivew was not accepted because information did not go to Family Centered Care Team (FCCT) which is a Quality committee of the Boat for review. We don't send report card information to the FCCT due to peer protection concerns. Review of process for making sure problem doe not reoccur: For 4th quarter 2015, anesthesia reviews for completed ASA documented will be reported FCCT and the Board of Managers by our Quality Manager. (see attached report card process with de-identificinformation will be presented quarterly to the FCCT and the Board by our Quality Manager Monitoring: Who: Quality analyst will complete chart reviews for documented ASA level. How: Random sample all procedures with 20 /mont for completed ASA review. Frequency: ASA documentation for 4th quarter of 2015. How long to monitor In 2016, de-identified anesthesia report card information will be presented to FCCT and the BOM quarterly.	on d pur ard e :-s to rt) ed i e er. of h	

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPLETI			ETED
		150149	B. WI	NG		10/07/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ATEWAY BLVD		
WOMEN'	S HOSPITAL THE				JRGH, IN 47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	INFECTION CONTROL						
Bldg. 00	410 IAC 15-1.5-2(a)					
	to patients, health visitors.	ronment that n exposure and risk care workers, and	S 05		Plan of Correction On review	, of	12/01/2015
		ent review, interview	5 03	034	Infection Control issues we fou		12/01/2015
	·	the facility failed to			4 areas of concern: 1. Hand	<u>a</u>	
		tion Control Policies in 3			Hygiene 2. On tour 10/6/2015	at	
		led to provide a healthful			0855 hours, accompanied by s		
	environment in five (5) instances (pelvic				member #2, Director of Clinica	ıl	
	ultrasound wands, GUS (glutaraldehyde				Operations, staff member N2,		
	ultrasound) soaking station, bone density				laboratory tech, was observed drawing blood on patient #5 in		
	patient pillow, re	habilitation massage			pre-and post-anesthesia care		
	cream, and porta	ble x-ray machine).			(PACU). Staff member #N2 wa		
	Findings include:				observed to have not followed hospital policy on hand hygien (using antimicrobial gel or soa and water) after removing glov	р	
		ospital Policy and			following the patient blood dra	W.	
	Procedure IC-02	last reviewed 03/2015			3. On tour 10/6/2015 at 0915		
	indicated that				hours, accompanied by staff member #2, PACU registered		
	B. Indic	cations for Alcohol Hand			nurse (RN) staff member #N1		
	Rub: If hands ar	re not visibly soiled, use			was observed starting an		
		waterless antiseptic			intravenous (IV) on patient N5		
		ly decontaminating			was observed that staff memb	er	
	hands.	-,			#N1 failed to do hand hygiene		
		re and after all patient			after removing gloves following the starting of the IV. Correction		
		•			of deficiency: We reviewed ou		
		et with the patient's			current policy on Hand Hygien		
	environment	1			IC-02 (see attached) and did n		
		re donning sterile gloves			find additional revisions. We ha		
		ting invasive devices			re-educated all staff with		
		removing gloves			mandatory web in service and		
	5. When	n moving from a			communicated in staff meeting		
			1		Review of process for making	9	

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 3 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		150149	B. WI	3. WING 10/07/20		2015	
				CTDEET A	DDDECC CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
VAVONATAL	IO LICODITAL THE				ATEWAY BLVD		
WOMEN	'S HOSPITAL THE			NEWBURGH, IN 47630			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	contaminated bo	dy site to clean when			sure problem does not reocc	ur:	
	providing patient care				We will continue to review and		
	2. On tour 10/6/2015 at 0855 hours,				report surveillance information		
					completed by staff. Education	า:	
		· · · · · · · · · · · · · · · · · · ·			Hand Hygiene education was		
	1 .	staff member #2,			provided to staff at		
	Director of Clini	ical Operations, staff			the Emergency Fair 10/21 and		
	member N2, lab	oratory tech, was			22, 2015. (see attached) There was also a Hand Hygiene	-	
	observed drawin	ig blood on patient #5 in			awareness poster project for s	taff	
		anesthesia care unit			to interact with in the cafeteria		
	(PACU). Staff member #N2 was				during Infection Prevention We	eek,	
	observed to have not followed hospital				October 18-24th. Additionally		
	_				mandatory web (see attached)) in	
	policy on hand hygiene (using				service for hand hygiene was		
	_	l or soap and water) after			assigned on 11/20/15 which		
	removing gloves	s following the patient			included an educational video		
	blood draw.				was created by hospital staff.		
					the end of the web-education shave to acknowledge	stan	
	3 On tour 10/6/	2015 at 0915 hours,			understanding that hand hygie	ne	
		staff member #2, PACU			is a priority and is non-negotia		
		•			This is all supported as a		
	_	(RN) staff member #N1			non-negotiables project by		
		arting an intravenous (IV)			hospital Administrative Counci	l.	
	on patient N5. I	t was observed that staff			Monitoring Who: Staff are		
	member #N1 fai	led to do hand hygiene			required to participate in our h		
	after removing g	gloves following the			hygiene monitoring program. V		
	starting of the IV	•			have a "Pay it Forward" progra	ım	
		•			where staff members choose	off	
	A Davisson of H	ognital Daliary on J			another staff member to pass the packet for	UII	
		ospital Policy and			instructions/observations.		
		onmental Sanitation, F-7,			Infection Prevention/Quality st	aff	
	last reviewed 4/0	01/2015, indicated:			track of the data and present		
	PURPOSE				information for discussion to		
	To prov	ide a clean environment			Family Centered Care Commit		
	•	nd debris for the surgical			Quarterly. Additionally the data	a is	
	patient and perso	•			posted on all nursing units for		
					staff to see the results. Results		
		EANING BETWEEN			are displayed by unit/departme	ent	
	PROCEDURES				and also by profession. How:		

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 4 of 15

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION (X3) DATE		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	COMPLETED	
		150149	B. WI	ING		10/07/	2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	8			ATEWAY BLVD			
WOMEN	'S HOSPITAL THE			NEWBURGH, IN 47630				
						1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROP	ΓE	COMPLETION DATE	
TAG	REGULATORT OR			TAG	Hand Hygiene audits		DATE	
		10. Horizontal surfaces of			Frequency: Continuous How			
	_	uipment that have been			long to monitor: Ongoing			
	involved in the p	procedure are cleaned			monitoring and feedback proje	ct		
	with hospital gra	nde disinfectant from the			2. Cleanliness: 5. On tour			
	least contaminat	ed to the worst			10/6/2015 at 1100 hours,			
	contaminated.				accompanied by staff member			
		14. Mop the floor using a			and #N3, Operating Room (OF	₹)		
	clean mon head	and a hospital approved			#5 in the facility Obstetric			
	disinfectant.	and a nospital approved			Emergency Department Delive (OBED) unit, was observed to	ery		
	distilicciant.				have dust and black and white			
	5 0 1 10/6/	/2015 / 11001			strings on the floor. Dust was a			
		2015 at 1100 hours,			observed on the instrument tra			
	1	staff member #2 and			Correction of deficiency: We	•		
	#N3, Operating 1	Room (OR) #5 in the			have reviewed our attached			
	facility Obstetric	Emergency Department			Environmental Sanitation police	y.		
	Delivery (OBED) unit, was observed to			We will re-educate staff and	·		
	have dust and bl	ack and white strings on			discuss deficiencies found dur survey. We will add spot check			
		was also observed on the			reviews of surgery rooms by	`		
	instrument tray.				completing the attached clean	ing		
	motiument tray.				checklist. Review of process	-		
	(Intervious of	staff member #N3 at time			making sure problem does n	ot		
					reoccur: Infection Prevention			
		that the room had been			staff will do ATP analyzer in ea	ach		
	cleaned and was	ready for a new patient.			OR room on a monthly basis.			
					Education: Staff will be			
	7. Review of the	e policy and procedure			re-educated in staff meetings regarding hospital policy for			
	(P&P) titled Effe	ective Cleaning and			cleaning of ORs. (See P&P F-	7		
	Designation of C	Clean and Unclean			Environmental Sanitation)			
		ipment indicated the			Monitoring: Who: Unit manag	ger		
	-	employees, physicians			How: In addition to existing log			
	and contracted e				that are to be kept for cleaning	l		
		ensuring patient care			schedules/documentation,	.,,		
		0.1			beginning in December, there	WIII		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	propriately cleaned and			be measurable monitoring of cleanliness in the OR by utilizing	na		
		re use. Cleaning is the			an ATP analyzer. Immediate	''y		
		ganic and inorganic			feedback will be provided as w	/ell		
	material from ob	pjects and surfaces. Only			as documented reports that wi			

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	
		150149	B. WI	NG		10/07/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ATEWAY BLVD		
WOMEN	'S HOSPITAL THE		NEWBURGH, IN 47630				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	clean equipment	is stored in the clean			be provided for all OR staff to	see	
	utility room. Eq	uipment is not to be			and included in the Infection		
		nediately around the sink			Prevention quarterly reporting	tO	
		nation from the water.			Family Centered Care Team. Random spot checks monthly		
	These items will				and to assess cleanliness of a	II	
		•			rooms Frequency: Monthly Ho		
		onnel at least daily and			long to monitor: for 6 months		
	when visibly soiled: portable x-ray				Reporting: Infection		
		ment carts The P&P			Preventionist will report data		
	was last reviewed/revised 12/13.				compiled to FCCT In addition		
					existing logs that are to be kep	ot	
	8. On 10/5/15 between 2:30pm and				for cleaning		
	4:00pm, during facility tour, in the				schedules/documentation. Beginning in December, there	will	
		Facility Manager, the			be measurable monitoring of	VVIII	
	following was of				cleanliness in the OR by utilizi	ng	
					an ATP analyzer. Immediate	5	
		nent cleaning room of			feedback will be provided as w	/ell	
	· ·	ate Perinatology, were			as documented reports that wi		
	_	nd wands hanging on a			be provided for all OR staff to	see	
	wall mounted op	en storage unit near the			and included in the Infection		
	dirty equipment	cleaning sink, heavy dust			Preventionist quarterly reportir to Family Centered Care Tean		
	atop the GUS cle	eaning unit with a large			9. On 10/6/15 between 1:00pi		
	-	peled bio-hazard next to			and 2:30pm, during facility tou		
		unit was observed.			the presence of A11, the follow		
	_	ensity testing room of			was observed: In the hospital	-	
		Center, was a pillow			radiology clean equipment		
	•	•			storage room was a portable		
	_	ow case on the patient			x-ray machine noted with heav	-	
	•	illow case appeared to			black dust on all surfaces of the white plastic/vinyl cord covers,		
		ands on the case and			lower and back portions of the		
	light brownish st	ains.			machine. Correction of		
	C. In the first pa	tient care room of the			deficiency: The portable had	а	
	hospital rehabilit	ation unit on a table near			thorough cleaning on 10-4-15,		
	_	able/bed was an open			the dust that accumulated		
	•	The supplies, including			happened in just 2 days.		
		cream, were observed			Therefore, we need to clean the	ie	
					portable on a daily basis.		
	with heavy white	e aust.			Radiology Lead created a log		

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 6 of 15

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		150149	B. WI	NG		10/07/	2015
				CTD FET A	ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
VAVONATINI	IO LICODITAL THE				ATEWAY BLVD		
WOMEN	'S HOSPITAL THE			NEWBURGH, IN 47630			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					sheet to document the date/tin	ne	
	9. On 10/6/15 b	etween 1:00pm and			and the initials of the person w		
		facility tour, in the			cleaned the portable. Since the		
		•			concern is that we are carrying		
	1 ^	, the following was			dust into NICU and other patie	nt	
		e hospital radiology clean			areas, the portable should be		
	equipment storaş	ge room was a portable			cleaned prior to the 4 a.m. portables, since that is when the	10	
	x-ray machine no	oted with heavy black			majority of x-rays are done.	10	
	dust on all surfaces of the white				Cleaning prior to each portable	9	
	plastic/vinyl cord covers, lower and back				exam is a good idea, but does		
	portions of the machine. In the bulk				need to be documented. Review	ew_	
	supply room were 2 boxes with outside				of process for making sure		
	** *				problem does not reoccur:		
		stored on shelves with			Radiology Coordinator will		
	clean supplies.				frequently observe cleanliness		
					equipment <u>Education:</u> Educa		
	10. In interview	on 10/5/15 at 2:45pm,			staff in unit meeting on cleaning	•	
	S1. Director of (Outpatient Operations,			schedule and document when		
		ginal wands were moved			completion of task. Monitorin	<u>g:</u>	
	_	dirty equipment cleaning			Who: Radiology Lead How: Random spot checks Frequen	· CV'	
	_				Weekly How long to monitor:		
	room after infect				months 3. Equipment cleanin		
		to remove them from			8. A. In the equipment cleaning		
	open storage in p	patient rooms and that the			room of off-site 1, Tri State	9	
	biohazard contai	ner in the room typically			Perinatology, were vaginal		
		patient linens. S1			ultrasound wands hanging on	а	
		on control had not			wall mounted open storage un		
		g the ultrasound wand			near the dirty equipment clean		
		_			sink, heavy dust atop the GUS		
	_ ~	dirty utility room. S1			cleaning unit with a large trash		
		at dusting of surfaces			type bin labeled bio-hazard ne	Χt	
	should be includ	ed in housekeeping. On			to and touching the unit was observed. 10. In interview on		
	10/6/15 at 11:30	am, S1 indicated the			10/5/15 at 2:45pm, S1, Directo	or of	
	housekeeping lo	g did not include			Outpatient Operations, indicate		
		atient care surfaces.			the vaginal wands were moved		
	Lastpe non p				storage in the dirty equipment		
	11 On 10/5/15	at 2:15mm S4 Danaity			cleaning room after infection		
		at 3:15pm, S4, Density			control recommendation to		
	I echnician, indi	cated he/she covers the			remove them from open storag	ge	

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 7 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			r /		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPL	ETED
		150149	B. W	ING		10/07/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER						
VA/ONAENII	IC LICCOITAL THE				ATEWAY BLVD		
WOMEN	S HOSPITAL THE			NEWBO	JRGH, IN 47630		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pillow case used	on the patient pillow			in patient rooms and that the		
	_	paper and takes the case			biohazard container in the roo	m	
		•			typically contained soiled patie	ent	
	_	approximately once per			linens. S1 indicated infection		
	week. S4 indica	ted the hospital, nor the			control had not approved mov	ing	
	department, had	a policy in place for			the ultrasound wand storage in	nto	
	-	dering the pillow case.			the dirty utility room. S1 also		
					indicated that dusting of surface	ces	
	10 1	10/5/15 + 2.50			should be included in		
		on 10/5/15 at 3:50pm,			housekeeping. On 10/6/15 at		
S5, Rehabilitation Director, indicated					11:30am, S1 indicated the		
equipment used during therapy often					housekeeping log did not inclu	ide	
		nount of white dust and			dust/wipe non-patient care		
					surfaces. Correction of		
	verified dust on	top of the massage			deficiency: Tri-State		
	cream.				Perinatology office area was		
					reviewed. The room labeled		
	13. In interview	on 10/6/15 at 1:25pm,			Utility room does have both		
		eam, indicated heavy			clean and dirty items separat		
		-			in the same room. Our plan f		
	_	resent on the cord			the ultrasound probes is to kee	•	
	covers, lower, ar	nd back portions of the			them in the room on the rack t	hat	
	portable x-ray m	achine.			is built in to the machine after		
					they are cleaned. We have		
	14 On 10/6/15	at 1:40pm, S7, Senior			ordered samples of color code		
		_			bags to place on clean probes		
		oordinator, indicated			"Green means go" bag over		
	boxes coming of	f trucks from shipping			probes will signal that they have		
	companies were	stored with their			been cleaned and also to prote	ect	
	contents in the si	upply room with clean			from dust etc. Review of		
	supplies.				process for making sure		
	supplies.				problem does not reoccur:		
					Educate staff responsible for	2014	
					cleaning probes to follow the r process and document when	ICW	
					completion of task. Monitoring	· ·	
					Who: Office Manager How:	4.	
					Random spot checks Frequer	ov.	
					-	_	
					Weekly How long to monitor: months 8. B. In the bone dens		
					testing room of off-site 2, Brea	•	
					_		
1			1		Center, was a pillow with a wh	iil C	

PRINTED: 01/21/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150149	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/07/2015
	ROVIDER OR SUPPLIER S HOSPITAL THE		4199 G	ADDRESS, CITY, STATE, ZIP CODE ATEWAY BLVD JRGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				pillow case on the patient table/bed. The pillow case appeared to have hair like stra on the case and light brownish stains. Correction of deficiency: We reviewed our current process and updated procedure for cleaning/chang pillow case after each case. Vocurrently have 3 pillows that a used for patient exams. The pillowcase is changed daily at table paper is used to cover the pillowcase. The table paper is changed after each exam. Additional pillow cases were added to stock on 10/9. We had a laundry service that comes and restocks the dirty pillowcase. This procedure is currently followed in the Bone Density Exam Room and the Ultrasound Exam Rooms by the staff involved. Review of process for making sure problem does not reoccur: Correct process for cleaning pillow and changing pillow case after each case was discussed and agreed to follow plan. We continue to review supplies and linen is sufficient for census. Education: Correct process for cleaning pillow case after each case we discussed and agreed to follow plan. Monitoring: Who: Breat Center Coordinator will spot check cleaning process after each patient How: Randomly Frequency: Monthly How long monitor: 3 months 8. A. In the	our ing Ve ure and he see d de will he or as w st

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 9 of 15

PRINTED: 01/21/2016 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 150149	A. BUILDING 00 B. WING		COMPLETED 10/07/2015		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
WOMEN'	S HOSPITAL THE		4199 GATEWAY BLVD NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				equipment cleaning room of off-site 1, Tri State Perinatolog were vaginal ultrasound wand hanging on a wall mounted op storage unit near the dirty equipment cleaning sink, heave dust atop the GUS cleaning unwith a large trash type bin labe bio-hazard next to and touching the unit was observed. 8. C. In the first patient care room of the hospital rehabilitation unit on a table near the patient care table/bed was an open box of supplies. The supplies, including a jar of massage cream, were observed with heavy white dusted to be determined by the composition of deficiency: Review of outpatient area for appropriate cleaning. We created an Outpatient Area Cleaning guideline and will document completion of cleaning on a lote to be determined by the cleaning personnel to follow the cleaning guidelines/schedule and document when completion of task occurs. This will be completed by end of November 2015. Monitoring: Who: Accreditation team starting 12/How: Random spot checks Frequency: Monthly How long monitor: 6 months #4 Supply storage 9. In the bulk supply room were 2 boxes with outside shipping labels stored on shell with clean supplies. Correction in the Radiology Area blue bin have been purchased for the	s seen /y nit eled ng n ne a ing st. ted g g. 15. to de ves n:		

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 10 of 15

PRINTED: 01/21/2016 FORM APPROVED OMB NO. 0938-0391

ABULIDING 00 COMPLETED 100/07/2015 NAME OF PROVIDER OR SUPPLIER WOMEN'S HOSPITAL THE KAJ ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Storage room and the cardboard shipping lobe on it must be immediately unpacked and thrown away. Review of process for making sure problem does not reaccure. Weekly How long to monitor: 3 monitor 14. On 10/6/15 at 1:40pm, S7, Senior Supply Chain Coordinator, indicated boxes coming off trucks from shipping companies were stored with their contents in the supply room with clean supplies. Correction of process for making sure problem does not reaccur. We have reviewed the AAMI guidelines, and under section 5.2 Receiving of Purchased or Loaner Items to be in shipping sure problem does not reaccur. We have reviewed the AAMI guidelines, and under section 5.2 Receiving of Purchased or Loaner Items to be transported.		T OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
NAME OF PROVIDER OR SUPPLIER WOMEN'S HOSPITAL THE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Storage room and the cardboard shipping boxes removed. Any box with the shipping label on it must be immediately unpacked and thrown away. Review of process. for making sure problem does not reoccur: Reeducate staff and do random audits for proper storage. Radiology staff were educated on bulk supply requirement and instructed to inform the Coordinator if additional blue bins are needed. Monitoring: Who: Radiology Lead How: Will do random spot checks Frequency: Weekly How long to monitor: 3 months 14. On 10/6/16 at 140pm, S7, Senior Supply Chain Coordinator, indicated boxes coming off trucks from shipping companies were stored with their contents in the supply room with clean supplies. Correction of deficiency: Review of process for making sure problem does not reoccur: We have reviewed the AAMI guidelines, and under section 5.2 Receiving of Purchased or Loaner Hems "To protect individual items. bulk items may be stored in shipping cartons in the central receiving area. Clean	AND FLAN	OF CORRECTION			<u>UU </u>	
WOMEN'S HOSPITAL THE (X4) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG ID PROMIPERS AND CORRECTION CONSISTED OF PREED TO THE APPROPRIATE CONSISTED OF THE APPROPRIATE CONSISTENCY OF THE APPROPRIATE CONSISTEN			100148			10/07/2013
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Loaner Items "To protect individual items, bulk items may be stored in shipping cartons in the central receiving area. Clean						11 0.2
individual items, bulk items may be stored in shipping cartons in the central receiving area. Clean						
be stored in shipping cartons in the central receiving area. Clean					•	nay
						=
or sterile items to be transported						
· · · · · · · · · · · · · · · · · · ·					,	
to central processing and storage						•
areas within the facility should be						ld be
removed from their external						hov
shipping containers before they enter the storage areas of the						
department." Our bulk supply						
room area is not within our central					1	

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 11 of 15

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		150149	B. WING		10/07/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
				ATEWAY BLVD		
WOMEN'	S HOSPITAL THE		NEWBU	JRGH, IN 47630		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	processing storage within the	DATE	
				hospital. There are actually tw sterile storage and processing areas located adjacent to each the operating room department Each nursing unit also has a storage and sterile supply room and outside shipping cartons a not to be used in these areas. Monitoring: Who: On safety rounds we monitor proper stor in clinical areas. How: Monthly reviews and all areas reviewed	n of this. mare age	
			a rotating basis Frequency:			
			Monthly How long to monitor	:		
				Ongoing		
S 0754 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECOR 410 IAC 15-1.5-4(
	(f) All inpatient rec those in subsectio document and cor to, the following:	· · · · · · · · · · · · · · · · · · ·				
	consent for proced for which it is requ by the informed co developed by the i	onsent policy medical staff and and consistent with				
	Based on doci	ument review and	S 0754	S 0754 Plan of Correction-	12/22/2015	
		v, the hospital failed		Appropriate Informed consent Survey report states: The block	='	
	to	,, the hospital inite		unit #2 was administered on	Ju	
		al malian of		8/14/15 at 9:18 pm; however t	he	
	follow hospita			medical record had no		
	informed con	sent as specified by		documentation of a signed	. aut	
	the informed	consent for one		consent. During surveyor ch review: Review of Blood	ıarı	
				I EVIEW. NEVIEW OF DIOUG		

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 12 of 15

		X1) PROVIDER/SUPPLIER/CLIA	i '	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		150149	B. WING		10/07/2015		
NAME OF DROWING OR SUIDNIED			STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER				GATEWAY BLVD			
WOMEN	'S HOSPITAL THE		NEWBURGH, IN 47630				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	patient identifier of twenty			Transfusion #2 review ID #683032301 with Transfusion	. #		
	patients recei	ving blood.		232587 a signed blood conse			
	Findings included: 1. Review of the policy, Blood and Blood Components Transfusion, Document # D - 5, reviewed 8/15/13, indicated:			on 6/10/15 was not accepted current for delivery stay 8/12-16/15. Internal chart review included: We reviewed the medical record	as		
				documentation of patient's st	av		
				which includes precertificatio	-		
				pre admission visit by an RN			
				which includes			
				teaching/instruction,and labo admission through discharge			
		nt (Exhibit A) must		and signing appropriate cons			
	be obtained prior to any blood			related to this condition			
	administratio	on. This consent is		ie.pregnancy. (See attachme			
	valid through the current hospitalization.			Medical record summary: Pa	tient		
				pre cert on 5/13/15 During pre-admission visit on 6/10/	15		
	nospitanzatio			the consent for blood			
				transfusion is signed for			
	2. Review of twenty patient medical records receiving blood indicated no consent form including:			delivery stay and education			
				related to labor and deliver	у		
				stay. Patient admitted on 8/12/15 Delivery by C-Section	ın.		
				on 8/13/15 On postop day 2,			
	lg.			Mann's progress note on 8/14			
	D-41-14-112			recommended Blood transfus			
	Patient #2:			x2 discussed with patient and	1		
	The blood u	ınit, #2a, was		husband with transfusion agreement from patient and			
	administered	on 8/14/15 at 9:18		husband. 1stblood transfus	sion_		
	p.m.; howeve	r, the medical		8/14/15 at 2115-post-op day			
	1 *	o documentation of		2ndblood transfusion on			
	a signed cons			8/15/15 at 0032- post-op day			
	a signed colls	CIII.		Discharged on 8/16 at 1055 - op day 3. Correction of	μυδι		
	3. In interview on 10/06/15 at 10:15 a.m., staff member #13			deficiency: We reviewed our			
				informed consent process rel	ated		
				to our scope of care for pre-n			
	I			care and the policy-Blood and	d		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150149	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/07/2015		
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TAG		the above and no entation was	TAG	Blood Components Transfing D-5 related to informed corand added clarified verbiagy valid consent to include reconspitalizations related to the same condition. (see yellow shaded area below): * Singuistration (see Exhibit A) must obtained prior to any blood administration (exception: litthreatening/emergent med condition). Informed consequences as a consent for any or blood product administ throughout the hospitalization a recurrent basis related same condition (i.e. pregnate with the process for massure problem does not rewith the manager with	usion nsent ge for a current the gened ust be life ical ent y blood stration ion or d to the ancy). king occur: and is ho to the ntation er s for all dated 0-5 and , 2015 ing: on ersees		
I				communication. How: Blo	od		

State Form Event ID: KFJH11 Facility ID: 002855 If continuation sheet Page 14 of 15

PRINTED: 01/21/2016 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 150149	A. BUILDING B. WING	<u>00</u>	DATE SURVEY OMPLETED 0/07/2015	
	PROVIDER OR SUPPLIER 'S HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 4199 GATEWAY BLVD NEWBURGH, IN 47630			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
			Transfusion audits are completed quarterly and reported twice a year to Family Centered Care Team and the Board of Managers in the Point ofCare/Blood /Laboratory Reports. Frequency: Continuous How long to monitor: Ongoing monitoring. * Blood and Blood Components Transfusion D-5 policy updates-Reviewed/Revised 10/20/15		

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