STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150149	A. BUILDING 00 B. WING	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S HOSPITAL THE	4199 GATEWAY BLVD NEWBURGH, IN 47630

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S 0000 Bldg. 00	This visit was for a State licensure survey. Dates of survey: 10/5/15 to 10/7/15 Facility #002855 JIC 10/28/15 IDR Committee held on 12-30-15; No changes made. JL	S 0000		
S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and interview, the quality assessment and performance improvement (QAPI) program failed to include anesthesia	S 0406	**Correction of deficiency:** **Currently physician report cards (QI data) are reviewed and sent to Medical Affairs annually for re-credentialing**	11/20/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	services in its review/evaluation. Findings include: 1. Review of the document titled Quality Assessment and Performance Improvement Plan 2015 indicated the scope of this plan includes all care and services provided by the hospital. Data is assessed at least quarterly. The plan was approved by the Board of Managers on 3/3/15. 2. Review of 2015 quality reports (02/19, 05/14 and 08/20/15) indicated there was no documentation of review of anesthesia services. 3. In interview on 10/7/15 at 12:55pm, A15, Quality Manager/Patient Safety Officer, confirmed all the above and no other documentation was provided by exit.		**process. Anesthesia report card process was reviewed with surveyor and Anesthesia reivew was not accepted because information did not go to Family Centered Care Team (FCCT) which is our Quality committee of the Board for review. We don't send report card information to the FCCT due to peer protection concerns. Review of process for making sure problem does not reoccur: For 4th quarter 2015, anesthesia reviews for completed ASA documented will be reported to FCCT and the Board of Managers by our Quality Manager. (see attached report) In 2016, our current report card process with de-identified information 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 of all procedures with 20 /month 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.**	
S 0554	410 IAC 15-1.5-2			

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Bldg. 00	INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on document review, interview and observation, the facility failed to follow two Infection Control Policies in 3 instances and failed to provide a healthful environment in five (5) instances (pelvic ultrasound wands, GUS (glutaraldehyde ultrasound) soaking station, bone density patient pillow, rehabilitation massage cream, and portable x-ray machine). Findings include: 1. Review of Hospital Policy and Procedure IC-02 last reviewed 03/2015 indicated that B. Indications for Alcohol Hand Rub**:** If hands are not visibly soiled, use an alcohol-based waterless antiseptic agent for routinely decontaminating hands. 1. Before and after all patient contact or contact with the patient's environment 2. Before donning sterile gloves 3. Inserting invasive devices 4. After removing gloves 5. When moving from a	S 0554	**Plan of Correction** On review of Infection Control issues we found 4 areas of concern: **1. Hand Hygiene** 2. On tour 10/6/2015 at 0855 hours, accompanied by staff member #2, Director of Clinical Operations, staff member N2, laboratory tech, was observed drawing blood on patient #5 in the pre-and post-anesthesia care unit (PACU). Staff member #N2 was observed to have not followed hospital policy on hand hygiene (using antimicrobial gel or soap and water) after removing gloves following the patient blood draw. 3. On tour 10/6/2015 at 0915 hours, accompanied by staff member #2, PACU registered nurse (RN) staff member #N1 was observed starting an intravenous (IV) on patient N5. It was observed that staff member #N1 failed to do hand hygiene after removing gloves following the starting of the IV. **Correction of deficiency**: We reviewed our current policy on Hand Hygiene IC-02 (see attached) and did not find additional revisions. We have re-educated all staff with mandatory web in service and communicated in staff meetings. **Review of process for making**	12/01/2015

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	contaminated body site to clean when providing patient care 2. On tour 10/6/2015 at 0855 hours, accompanied by staff member #2, Director of Clinical Operations, staff member N2, laboratory tech, was observed drawing blood on patient #5 in the pre-and post anesthesia care unit (PACU). Staff member #N2 was observed to have not followed hospital policy on hand hygiene (using antimicrobial gel or soap and water) after removing gloves following the patient blood draw. 3. On tour 10/6/2015 at 0915 hours, accompanied by staff member #2, PACU registered nurse (RN) staff member #N1 was observed starting an intravenous (IV) on patient N5. It was observed that staff member #N1 failed to do hand hygiene after removing gloves following the starting of the IV. 4. Review of Hospital Policy and Procedure Environmental Sanitation, F-7, last reviewed 4/01/2015, indicated: PURPOSE To provide a clean environment free from dust and debris for the surgical patient and personnel. C. CLEANING BETWEEN PROCEDURES		**sure problem does not reoccur**: We will continue to review and report surveillance information completed by staff. **Education:** Hand Hygiene education was provided to staff at the Emergency Fair 10/21 and 22, 2015. (see attached) There was also a Hand Hygiene awareness poster project for staff to interact with in the cafeteria during Infection Prevention Week, October 18-24th. Additionally a mandatory web (see attached) in service for hand hygiene was assigned on 11/20/15 which included an educational video that was created by hospital staff. At the end of the web-education staff have to acknowledge understanding that hand hygiene is a priority and is non-negotiable. This is all supported as a non-negotiables project by hospital Administrative Council. **Monitoring Who:** Staff are required to participate in our hand hygiene monitoring program. We have a “Pay it Forward” program where staff members choose another staff member to pass off the packet for instructions/observations. Infection Prevention/Quality staff track of the data and present information for discussion to Family Centered Care Committee Quarterly. Additionally the data is posted on all nursing units for staff to see the results. Results are displayed by unit/department and also by profession. **How:**	

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	10. Horizontal surfaces of furniture and equipment that have been involved in the procedure are cleaned with hospital grade disinfectant from the least contaminated to the worst contaminated. 14. Mop the floor using a clean mop head and a hospital approved disinfectant. 5. On tour 10/6/2015 at 1100 hours, accompanied by staff member #2 and #N3, Operating Room (OR) #5 in the facility Obstetric Emergency Department Delivery (OBED) unit, was observed to have dust and black and white strings on the floor. Dust was also observed on the instrument tray. 6. Interview of staff member #N3 at time of tour indicated that the room had been cleaned and was ready for a new patient. 7. Review of the policy and procedure (P&P) titled Effective Cleaning and Designation of Clean and Unclean Patient Care Equipment indicated the following: All employees, physicians and contracted employees are accountable for ensuring patient care equipment is appropriately cleaned and disinfected before use. Cleaning is the removal of all organic and inorganic material from objects and surfaces. Only		Hand Hygiene audits **Frequency:** Continuous **How long to monitor:** Ongoing monitoring and feedback project **2. Cleanliness:** 5. On tour 10/6/2015 at 1100 hours, accompanied by staff member #2 and #N3, Operating Room (OR) #5 in the facility Obstetric Emergency Department Delivery (OBED) unit, was observed to have dust and black and white strings on the floor. Dust was also observed on the instrument tray. **Correction of deficiency**: We have reviewed our attached Environmental Sanitation policy. We will re-educate staff and discuss deficiencies found during survey. We will add spot check reviews of surgery rooms by completing the attached cleaning checklist. **Review of process for making sure problem does not reoccur:** Infection Prevention staff will do ATP analyzer in each OR room on a monthly basis. **Education:** Staff will be re-educated in staff meetings regarding hospital policy for cleaning of ORs. (See P&P F-7 Environmental Sanitation) **Monitoring: Who:** Unit manager **How:** In addition to existing logs that are to be kept for cleaning schedules/documentation, beginning in December, there will be measurable monitoring of cleanliness in the OR by utilizing an ATP analyzer. Immediate feedback will be provided as well as documented reports that will	

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	clean equipment is stored in the clean utility room. Equipment is not to be stored on or immediately around the sink to avoid contamination from the water. These items will be cleaned by department personnel at least daily and when visibly soiled: portable x-ray machines, equipment carts... . The P&P was last reviewed/revised 12/13. 8. On 10/5/15 between 2:30pm and 4:00pm, during facility tour, in the presence of A11, Facility Manager, the following was observed: A. In the equipment cleaning room of off-site 1, Tri State Perinatology, were vaginal ultrasound wands hanging on a wall mounted open storage unit near the dirty equipment cleaning sink, heavy dust atop the GUS cleaning unit with a large trash type bin labeled bio-hazard next to and touching the unit was observed. B. In the bone density testing room of off-site 2, Breast Center, was a pillow with a white pillow case on the patient table/bed. The pillow case appeared to have hair like strands on the case and light brownish stains. 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 dust.		be provided for all OR staff to see and included in the Infection Prevention quarterly reporting to Family Centered Care Team. Random spot checks monthly and to assess cleanliness of all rooms **Frequency:** Monthly **How long to monitor:** for 6 months **Reporting:** Infection Preventionist will report data compiled to FCCT In addition to existing logs that are to be kept for cleaning schedules/documentation. Beginning in December, there will be measurable monitoring of cleanliness in the OR by utilizing an ATP analyzer. Immediate feedback will be provided as well as documented reports that will be provided for all OR staff to see and included in the Infection Preventionist quarterly reporting to Family Centered Care Team. 9. On 10/6/15 between 1:00pm and 2:30pm, during facility tour, in the presence of A11, the following was observed: In the hospital radiology clean equipment storage room was a portable x-ray machine noted with heavy black dust on all surfaces of the white plastic/vinyl cord covers, lower and back portions of the machine. **Correction of deficiency:** The portable had a thorough cleaning on 10-4-15, so the dust that accumulated happened in just 2 days. Therefore, we need to clean the portable on a daily basis. Radiology Lead created a log	

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	9. On 10/6/15 between 1:00pm and 2:30pm, during facility tour, in the presence of A11, the following was observed: In the hospital radiology clean equipment storage room was a portable x-ray machine noted with heavy black dust on all surfaces of the white plastic/vinyl cord covers, lower and back portions of the machine. In the bulk supply room were 2 boxes with outside shipping labels stored on shelves with clean supplies. 10. In interview on 10/5/15 at 2:45pm, S1, Director of Outpatient Operations, indicated the vaginal wands were moved to storage in the dirty equipment cleaning room after infection control recommendation to remove them from open storage in patient rooms and that the biohazard container in the room typically contained soiled patient linens. S1 indicated infection control had not approved moving the ultrasound wand storage into the dirty utility room. S1 also indicated that dusting of surfaces should be included in housekeeping. On 10/6/15 at 11:30am, S1 indicated the housekeeping log did not include dust/wipe non-patient care surfaces. 11. On 10/5/15 at 3:15pm, S4, Density Technician, indicated he/she covers the		sheet to document the date/time and the initials of the person who cleaned the portable. Since the concern is that we are carrying dust into NICU and other patient areas, the portable should be cleaned prior to the 4 a.m. portables, since that is when the majority of x-rays are done. Cleaning prior to each portable exam is a good idea, but does not need to be documented. **Review of process for making sure problem does not reoccur:** Radiology Coordinator will frequently observe cleanliness of equipment **Education:** Educate staff in unit meeting on cleaning schedule and document when completion of task. **Monitoring: Who:** Radiology Lead **How:** Random spot checks **Frequency:** Weekly **How long to monitor:** 3 months **3. Equipment cleaning:** 8. A. In the equipment cleaning room of off-site 1, Tri State Perinatology, were vaginal ultrasound wands hanging on a wall mounted open storage unit near the dirty equipment cleaning sink, heavy dust atop the GUS cleaning unit with a large trash type bin labeled bio-hazard next to and touching the unit was observed. 10. In interview on 10/5/15 at 2:45pm, S1, Director of Outpatient Operations, indicated the vaginal wands were moved to storage in the dirty equipment cleaning room after infection control recommendation to remove them from open storage	

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	pillow case used on the patient pillow with disposable paper and takes the case home to laundry approximately once per week. S4 indicated the hospital, nor the department, had a policy in place for changing or laundering the pillow case. 12. In interview on 10/5/15 at 3:50pm, S5, Rehabilitation Director, indicated equipment used during therapy often creates a large amount of white dust and verified dust on top of the massage cream. 13. In interview on 10/6/15 at 1:25pm, S6, Radiology Team, indicated heavy black dust was present on the cord covers, lower, and back portions of the portable x-ray machine. 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.		in patient rooms and that the biohazard container in the room typically contained soiled patient linens. S1 indicated infection control had not approved moving the ultrasound wand storage into the dirty utility room. S1 also indicated that dusting of surfaces should be included in housekeeping. On 10/6/15 at 11:30am, S1 indicated the housekeeping log did not include dust/wipe non-patient care surfaces. **Correction of deficiency: Tri-State Perinatology office area was reviewed. The room labeled Utility room does have both clean and dirty items separated in the same room.** Our plan for the ultrasound probes is to keep them in the room on the rack that is built in to the machine after they are cleaned. We have ordered samples of color coded bags to place on clean probes. "Green means go" bag over probes will signal that they have been cleaned and also to protect from dust etc. **Review of process for making sure problem does not reoccur:** Educate staff responsible for cleaning probes to follow the new process and document when completion of task. **Monitoring: Who:** Office Manager **How:** Random spot checks **Frequency:** Weekly **How long to monitor:** 3 months 8. B. In the bone density testing room of off-site 2, Breast Center, was a pillow with a white	

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			pillow case on the patient table/bed. The pillow case appeared to have hair like strands on the case and light brownish stains. **Correction of deficiency:** We reviewed our current process and updated our procedure for cleaning/changing pillow case after each case. We currently have 3 pillows that are used for patient exams. The pillowcase is changed daily and 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 have a laundry service that comes daily and restocks the dirty pillowcases for clean. This procedure is currently followed in the Bone Density Exam Room and the 2 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 will continue to review supplies and linen is sufficient for census. **Education:** Correct process for cleaning pillow and changing pillow case after each case was discussed and agreed to follow plan. **Monitoring:** Who: Breast Center Coordinator will spot check cleaning process after each patient How: Randomly Frequency: Monthly How long to monitor: 3 months 8. A. In the	

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			equipment cleaning room of off-site 1, Tri State Perinatology, were vaginal ultrasound wands hanging on a wall mounted open storage unit near the dirty equipment cleaning sink, heavy dust atop the GUS cleaning unit with a large trash type bin labeled 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 dust. **Correction of deficiency:** Review of outpatient area for appropriate cleaning. We created an Outpatient Area Cleaning guideline and will document completion of cleaning on a log. **Review of process for making sure problem does not reoccur:** Educate 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: Accrediation team starting 12/15. How: Random spot checks Frequency: Monthly How long to monitor: 6 months **#4 Supply storage** 9. In the bulk supply room were 2 boxes with outside shipping labels stored on shelves with clean supplies. Correction: in the Radiology Area blue bins have been purchased for the	

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			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 10/6/15 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 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 Items *"To protect individual items, bulk items may be stored in shipping cartons in the central receiving area. Clean or sterile items to be transported to central processing and storage areas within the facility should be removed from their external shipping containers before they enter the storage areas of the department."* Our bulk supply room area is not within our central	

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			processing storage within the hospital. There are actually two sterile storage and processing areas located adjacent to each of the operating room departments. Each nursing unit also has a storage and sterile supply room and outside shipping cartons are not to be used in these areas. **Monitoring: Who:** On safety rounds we monitor proper storage in clinical areas. **How:** Monthly reviews and all areas reviewed on a rotating basis **Frequency:** Monthly **How long to monitor:** Ongoing	
S 0754 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. **Based on document review and staff interview, the hospital failed to follow hospital policy of informed consent as specified by the informed consent for one**	S 0754	S 0754 Plan of Correction- Appropriate Informed consent: Survey report states: The blood unit #2 was administered on 8/14/15 at 9:18 pm; however the medical record had no documentation of a signed consent. **During surveyor chart review**: Review of Blood	12/22/2015

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	patient identifier of twenty patients receiving blood. **Findings included:** **1. Review of the policy, Blood and Blood Components Transfusion, Document # D - 5, reviewed 8/15/13, indicated: Signed consent (Exhibit A) must be obtained prior to any blood administration. This consent is valid through the current hospitalization.** **2. Review of twenty patient medical records receiving blood indicated no consent form including:** **Patient #2:** **--The blood unit, #2a, was administered on 8/14/15 at 9:18 p.m.; however, the medical record had no documentation of a signed consent.** **3. In interview on 10/06/15 at 10:15 a.m., staff member #13**		Transfusion #2 review ID #683032301 with Transfusion # 232587 a signed blood consent on 6/10/15 was not accepted as current for delivery stay 8/12-16/15. **Internal chart review included:** We reviewed the medical record documentation of patient's stay which includes precertification, pre admission visit by an RN which includes teaching/instruction,and labor admission through discharge and signing appropriate consents related to this condition ie.pregnancy. (See attachments) Medical record summary: Patient pre cert on 5/13/15 During **pre-admission visit on 6/10/15** the **consent for blood transfusion is signed for delivery stay and education related to labor and delivery stay. Patient admitted on 8/12/15 Delivery by C-Section on 8/13/15** On postop day 2, Dr Mann's progress note on 8/14/15 recommended Blood transfusion x2 discussed with patient and husband with transfusion agreement from patient and husband. **1stblood transfusion 8/14/15 at 2115-post-op day 1. 2ndblood transfusion on 8/15/15 at 0032- post-op day 2.** Discharged on 8/16 at 1055 -post op day 3. **Correction of deficiency:** We reviewed our informed consent process related to our scope of care for pre-natal care and the policy-Blood and	

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	150149	A. BUILDING 00 B. WING	10/07/2015

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	confirmed all the above and no other documentation was provided by exit.		Blood Components Transfusion D-5 related to informed consent and added clarified verbiage for a valid consent to include recurrent hospitalizations related to the same condition.(see yellow shaded area below): * Signed consent (see Exhibit A) must be obtained prior to any blood administration (exception:life threatening/emergent medical condition). Informed consent serves as a consent for any blood or blood product administration throughout the hospitalization or on a recurrent basis related to the same condition (i.e. pregnancy). **Review of process for making sure problem does not reoccur**: We will continue to review and report any incomplete Blood Transfusion record. Any incomplete documentation is reported to the manager who communicates information to the nurse to complete documentation in a timely manner. Manager monitors documentation deficiencies for trends **Education: Web in service was assigned to all clinical staff related to updated** policy Blood and Blood Components Transfusion D-5 and assigned on December 22, 2015 to all employees. **Monitoring: Who:** Staff is required to complete a blood transfusion record. NICU Manager oversees the process for incomplete documentation and communication. **How:** Blood	

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			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	