

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151328		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/13/2013	
NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2900 W 16TH ST BEDFORD, IN 47421			
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 6/11/2013 through 6/13/2013</p> <p>Facility Number: 004683</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 06/17/13</p>	S000000					

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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S000332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on policy and procedure review, job description review, personnel file review, and interview, the facility failed to ensure all registered nurses (RNs) and paramedics had documentation of annual competency in blood transfusion administration for 2 of 2 intensive care (ICU) nurses (#P2 and P4), 1 of 2 emergency department (ED) nurses (#P3), and 2 of 2 paramedics (#M1 and M2) whose files were reviewed.</p> <p>Findings included:</p> <p>1. The facility policy "Annual Mandatory Education Competency for Nursing &amp; Patient Care Services", last reviewed July 2012, indicated, "A. Annually Mandatory Inservice Day (MID) education/competency will be completed</p>	S000332	<p>1. Annual mandatory Education, Competency For Nursing &amp; Patient Care Services policy and Paramedic Job's Manual specific to "Transfer-Blood Transfusion" reviewed <b>Responsible Persons:</b> Director of Emergency Director of ICU Director of EMS Director of Med/Surg Completed 6-27-2013 2. Emergency Staff, ICU Staff, and Paramedics who did not receive 2012 Annual Blood Transfusion Education will complete that education by 7-19-2013. <b>Responsible Persons:</b> Education Coordinator Director of Emergency Director of ICU Director of EMS Director of Med/Surg To be completed by 7-20-2013. Nursing and Patient Care Services Mandatory education process reviewed and revised. The Education</p>	07/20/2013			

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	<p>in the following areas: ...blood transfusions/reactions."</p> <p>2. The Paramedic Job Description indicated, "Paramedic must possess the required knowledge and skills to appropriately care for and manage neonatal, infant, pediatric, adult, and elderly patients. ...General Requirements: Attends staff meetings and completes mandatory in-services and requirements and competency evaluations on time. Demonstrates competency at all levels in providing care to all patients based on age, gender, weight, and demonstrated needs." One of the skills in the Paramedic's Job Manual, approved September 1, 2011, was "Transfer-Blood Transfusion" with step-by-step guidelines for the procedure.</p> <p>3. The personnel files for staff members #P2 and P4, ICU nurses, lacked documentation of annual blood transfusion competency/training for 2012.</p> <p>4. The personnel file for staff member #P3, an ED nurse, lacked documentation of annual blood transfusion competency/training for 2012.</p> <p>5. The personnel files for staff members #M1 and M2, paramedics, indicated documentation of blood transfusion</p>		<p>Department along with the patient care department Directors are to offer and send staff to annual mandatory training provided by the Education Department to assure and track compliance with mandatory educations such as Blood Transfusion. <b>Responsible Persons:</b> Education Coordinator Director of Emergency Director of ICU Director of EMS Director of Med/Surg Completed 6-27-20134. Mandatory Annual Education for Nursing and Paramedics on Blood Transfusion is scheduled for September and October of 2013 <b>Responsible Persons:</b> Education Coordinator Director of Emergency Director of ICU Director of EMS Director of Med/Surg 2013 Mandatorys to be completed in Sept. &amp; October5. Education will track the attendance of the Nursing Staff and Paramedics receiving the Mandatory Blood Transfusion Education and communicate any staff who have not completed annual training to their Department Director. <b>Responsible Persons:</b> Education Coordinator Education Assistant Data to be sent to Department Heads Monthly beginning 8-1-20136. Monitoring for compliance of Blood Transfusion Annual education will be sent to the Director of Quality Monthly X3</p>		

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	<p>competency/training on 06/24/11, but lacked documentation of any training/competency since that time.</p> <p>6. At 3:15 on 06/13/13, staff members #A1 and M2 indicated training was provided to paramedics in June 2011 prior to the September 1, 2011 policy change to allow paramedics to administer blood transfusions without a nurse being present. Apparently training had not been provided since then. Staff member #A1 indicated all nurses should have annual training/competency.</p>		<p>then Quarterly X3. <b>Responsible Persons:</b> Education Coordinator Education Assistant Data to be sent to Quality beginning with 8-1-2013 data.</p>		

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure CT Scanner, Endoscopy, Infusion Therapy, Mammography, MRI, Nuclear Medicine, Security, Speech Pathology, and Ultrasound services were part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <p>1. Indiana University Health Bedford Hospital Quality Improvement Plan (last reviewed and approved 10/2012) implements all service with direct or indirect</p>	S000406	<p>1. Hospital Document Request QA/PI Monitors document provided by ISDH Surveyor reviewed for applicable services. <b>Responsible Person:</b> Director of Quality, Compliance, and Risk – Completed 6-28-20132. Review Facility Quality Plan <b>Responsible Person:</b> Director of Quality, Compliance, and Risk – Completed 6-28-2013 3. Add the following services to the facility Monthly Quality Monitoring Report: CT Scanner, Endoscopy, Infusion Therapy, Mammography, MRI, Nuclear Medicine, Security, Speech Pathology, and Ultrasound. <b>Responsible Person:</b> Director of Quality, Compliance, and Risk – Completed 7-10-20134. QA/PI studies will be sent to the Quality Department Monthly for inclusion in the Monthly Quality Monitoring Report .</p>	07/10/2013			

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	<p>impact on patient care quality shall be reviewed under the quality improvement program.</p> <p>2. On 6/11/2013, 2012 &amp; 2013 Indiana University Health Bedford Hospital Quality Reports were reviewed with staff members #1 and #3. The quality reports evidenced the following 9 services were not identified and evaluated as parts of the hospital's comprehensive quality assessment and improvement plan: CT Scanner, Endoscopy, Infusion Therapy, Mammography, MRI, Nuclear Medicine, Security, Speech Pathology, and Ultrasound.</p> <p>3. At 1:45 PM 6/11/2013, staff member #3 indicated the 9 services: CT Scanner, Endoscopy, Infusion Therapy, Mammography, MRI, Nuclear Medicine, Security, Speech Pathology, and Ultrasound were not identified as being evaluated as part of of it's comprehensive quality assessment and improvement (QA&amp;I) program.</p>		<p><b>Responsible Persons:</b>  <b>Diagnostic Imaging Director-</b> for: CT Scanner, Mammography, MRI, Nuclear Medicine, and Ultrasound  <b>Surgery Director – for:</b> Endoscopy  <b>Therapies Director – for:</b> Speech Pathology  <b>Plant Operations Director – for:</b> Security  <b>Infusion Director – for:</b> Infusion Therapy                      Data to be sent to Quality Beginning with 7-1-2013 data</p>		

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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 maintain an environment that minimized risk to patients, visitors, and/or employees for 2 of 2 units toured, Main Housekeeping Closet and Morgue.</p> <p>Findings include:</p> <p>1. At 10:45 AM on 6/12/2013, the Main Housekeeping Closet was toured. The Main Housekeeping Closet stores paper supplies, patient room disinfectants, cleaners, housekeeping supplies. The items stored in the room are for cleaning and disinfecting rooms throughout the hospital. However, stored on a middle shelf with disinfectant Dispatch was a gallon container of Round-up Grass and Weed Killer. The label on the container states</p>	S000554	<p><b>Housekeeping Closet</b> 1. Round -up Grass and Weed Killer removed from Housekeeping Closet. <b>Responsible Person:</b> Director of Plant Operations Completed 6-12-2013 2. Re-education with Environmental Services Staff to the appropriate materials to be stored in the Main Housekeeping Closet <b>Responsible Person:</b> Director of EVS To be completed by 7-31-20133. Appropriateness of materials stored in the Main Housekeeping closet added to the EVS Rounding checklist. <b>Responsible Person:</b> Director of EVS Completed 7-10-2013 4. Monitoring of compliance with appropriate materials stored in the Main Housekeeping closet will be sent to the Director of Quality monthly X3 then Quarterly X 3 to assure compliance. <b>Responsible Persons:</b> Director of EVS Data to be sent to Quality beginning with 7-1-2013 data <b>Morgue</b> 1 Lab supervisor discarded specimen left on the sink. <b>Responsible Person:</b> Director of Lab Completed 6-14-20132. Histology Staff educated to check</p>	07/31/2013	

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	<p>hazardous to your health and the product is to be used for the outside only.</p> <p>2. At 10:50 AM, staff member #6 indicated the grass killer should not be stored in the housekeeping closet with other items that are to be used in patient rooms.</p> <p>3. At 11:30 AM on 6/12/2013, the Morgue was toured. On the counter adjacent to the hand washing sink was a blue plastic tray that contained a lab tube. The lab tube had a patient's name on it and it was dated 7/19/2010. Within the clear lab tube was a reddish color liquid.</p> <p>4. At 11:35 AM on 6/12/2013, staff member #6 indicated he/she has no idea who left the lab tube on the counter and why it was dated 7/19/2010.</p> <p>5. At 11:45 AM on 6/12/2013, there was a package of clean linen stored on the floor of the Morgue.</p>		<p>morgue for cleanliness and appropriate specimen storage daily. Added to daily checklist <b>Responsible Person:</b> Director of Lab Completed 7-12-2013 3. Monitoring of compliance with morgue cleanliness and appropriate specimen storage will be sent to the Director of Quality monthly X3 then Quarterly X 3 to Assure compliance. <b>Responsible Persons:</b> Director of Lab Data to be sent to Quality beginning with 7-1-2013 data.</p>				

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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 observation and staff interview, the facility failed to maintain the cabinet storage areas located under the Laboratory, Morgue, and Nuclear Medicine Hot Lab Hand Washing sinks neat and storage free from possible sewage contamination.</p> <p>Findings included:</p> <p>1. At 9:55 AM on 6/12/2013, the Laboratory designated Hand Washing sink was observed storing disinfectant wipes, cleaners, laboratory supplies, and other miscellaneous items in the counter cabinet under the sewage drainage system of the hand washing sink. Several items located in the brainwashing sink's counter cabinet were observed with excess debris</p>	S000592	<p>1. E-Mail communication sent to all Department Directors notifying them of the citation and the plan to screw all cabinets under sinks shut by 7-12-2013. <b>Responsible Person:</b> Director of Quality, Compliance, and Risk – Completed 6-28-2013 2. Work order generated for Plant Operations staff to screw all cabinets under the sinks closed on 6-24-2013 <b>Responsible Person:</b> Director of Plan Operations Completed 7-3-2013 3. Monitoring of Compliance with all cabinets under the sinks being screwed shut will occur during Environment of Care Rounding which is twice a year for patient care areas and once a year for non-patient care areas. Added to the Rounding Checklist. <b>Responsible</b></p>	07/10/2013			

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	<p>on them. The counter was unorganized and was not maintained in a sanitary manner.</p> <p>2. At 10:30 AM on 6/12/2013, the Nuclear Medicine Hot Lab Hand Washing counter cabinet was inspected. The counter cabinet under the hot lab hand washing sink was cluttered with assorted supplies, chemicals, and paper goods. Items under the sink basin was observed with water spots and other debris on them.</p> <p>3. At 11:05 AM on 6/12/2013, the Morgue hand washing counter cabinet was inspected. The cabinet located under the hand washing sink was assorted lab supplies, paper towels, and other miscellaneous items. The unwrapped rolled white paper towels were observed with a reddish spots on them. The hand washing sink's counter was observed cluttered and disorganized.</p> <p>4. At 12:10 PM on 6/12/2013, staff member #6 indicated hospital procedures requires all hospital employees not to store anything under the sinks throughout the hospital. The storage under the sinks is an infection control concern.</p>		<p><b>Person:</b> Director of Quality, Compliance, and Risk – Completed 7-10-2013</p>				

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S000594	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ii) Universal precautions, including infectious waste management.</p> <p>Based on document review and observation, the facility failed to ensure the Laboratory Department had an accessible hand washing sink when needed and to meet the Universal Precaution requirements.</p> <p>Findings included:</p> <p>1. Universal Precaution 410 IAC 1-4-8 states, "All covered individuals and health care workers under this rule shall comply with the requirements imposed under the Indiana occupational safety and health administration's bloodborne</p>	S000594	<p>1. Work order submitted to Plant Operations on 7-8-2013 to designate the sink next to the DXC 600 Machine as a "Hand Washing Only" sink <b>Responsible Person:</b> Director of Plant Operations Completed 7-8-2013 2. Hand Washing Only Sink labeled by 7-12-2013 <b>Responsible Person:</b> Director of Lab Completed 7-12-2013 3. Staff education to use the designated Hand Washing Only sink for hand washing. <b>Responsible Person:</b> Director of Lab To be completed by 7-31-2013 4. Monitoring for compliance of staff utilizing the Hand Washing Only sink will be sent to the Director of Quality Monthly X3 then Quarterly X3. <b>Responsible Person: Director of Lab</b> Data to be sent to Quality</p>	08/31/2013	

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	<p>pathogens standards (as found in 29 CFR 1910.1030). Hand hygiene shall be performed before and after touching a potential source, before a clean or aseptic procedure, after a risk of body fluid exposure, after contact with inanimate surfaces and objects in the immediate vicinity of a potential source, and after removing gloves." The requirement also describes hand washing shall be performed in a sink that is designated for hand washing only.</p> <p>2. At 9:50 AM on 6/12/2013, the Laboratory Department was toured Staff member #22 identified the designated hand washing sink for the Laboratory employees. The hand washing sink was also observed with an eyewashing station mounted to the faucet. The designated hand washing station had evidence of white encrusted debris on the inside of the sink basin. Behind the faucet was three assorted bottles of of staining liquid that is used for testing. The sink</p>		beginning with 8-1-2013 data.		

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	<p>also had assorted lab rubes surrounding the sink basin. A Vidas Service Analyzer was observed stored on the counter to the right of the sink basin. The analyzer was observed with 2 black discharge tubes laying into the hand washing sink's basin. The discharge tubes are for draining of biohazard material that would be discharged from the machine. The hand washing sink was not observed for hand washing use only but was observed as an utility sink besides being a hand washing sink for the employees.</p> <p>3. The Vidas Series Analyzer operating manual indicates the discharge material is considered potentially infectious materials. When handling potentially infectious materials, follow OSHA requirements for the Bloodborne Pathogens Standards.</p>				

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on policy and procedure review, observation, document review, and interview, the facility failed to follow the manufacturer's instructions for disinfecting equipment in the Ultrasound Room and in the Central Processing area.</p> <p>Findings included:</p> <p>1. The facility policy "High Level Disinfection Using Glutaraldehyde or Ortho-phthaldehyde Solutions", last reviewed 11/30/12, indicated, "VI. Procedures: A. All users of Glutaraldehyde or Ortho-phthaldehyde must follow written departmental and manufacturer guidelines regarding utilization, safety, and monitoring. ...F. Manufacturer's instructions for rinsing</p>	S000596	<p>1. Researched the manufacture's literature on the facility products requiring Cidex for decontamination to determine if other decontamination methods are available <b>Responsible Person:</b> Director of Central Processing Completed 7-12-20132. Cidex policy reviewed and revised to include the following: a. Specific directions for labeling of test strips with an open date and expiration date not to exceed 90 days. b. Cidex OPE Solution jug to be labeled with an expiration date not to exceed 75 days afer opening. c. Covered Cidex containers must be labeled with the product and an expiration date not to exceed 28 days. d. Specific directions for the 1 minute</p>	07/31/2013			

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	<p>will be followed. G. Glutaraldehyde or Ortho-phthaldehyde concentration levels must be monitored prior to each use with an approved test strip. If the test strip fails, the solution must be discarded. Manufacturer's instructions for utilizing test strips must be followed to ensure the quality of the test strip monitoring. ...J. Glutaraldehyde or Ortho-phthaldehyde solutions must be labeled with the name of chemical, expiration date, and appropriate hazard symbol."</p> <p>2. The facility policy "Ultrasound Policy for Disinfecting Probes after Vaginal Use", last reviewed May 14, 2013, indicated, "1. Gloves, gowns, masks with splash guard, must be used every time a probe is disinfected. 2. Cidex disinfectant solution is used on all probes."</p> <p>3. During the tour of the Ultrasound Room at 10:15 AM on 06/12/13, accompanied by staff member #A23, high level disinfection with Cidex OPA was observed for use with the Toshiba ultrasound transducers.</p> <p>4. At 10:15 AM on 06/12/13, staff member #A23 indicated after the probes were disinfected, he/she took them to surgery and rinsed them for about a minute under tap water. He/she indicated</p>		<p>immersion time in the Cidex OPE solution for disinfection and the three 1 minute immersions in separate basins containing 8.2 quarts or larger of prepackaged sterile water for rinsing. f. Re-enforced the policy directions for the use of gloves, protective eyewear, and gloves during cleaning and disinfection with Cidex OPE. <b>Responsible Person:</b> Director of Central Processing Completed 7-12-2013</p> <p>3. Central Processing Staff to be educated on the revised Cidex policy and processes by 7-31-2012 <b>Responsible Person:</b> Director of Central Processing To be completed by 7-31-20134 Monitoring of compliance in following the revised Cidex policy and procedures will be sent to the Quality Director Monthly X3 then Quarterly X3. <b>Responsible Person:</b> Director of Central Processing Data to be sent to Quality beginning with 8-1-2013 data</p>				

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	<p>gloves and aprons were always used when handling the Cidex, but although there was a face shield in surgery, he/she did not always wear it.</p> <p>5. During the tour of the Central Processing area at 2:00 PM on 06/12/13, accompanied by staff members #A1, A16, and A17, a small, covered container of Cidex OPA solution was observed on the counter. The container was not labeled with an expiration date for the solution. An open, but not dated, container of test strips for the Cidex was also on the counter. Label directions indicated to date when opened and discard after 90 days.</p> <p>6. At 2:05 PM on 06/12/13, staff member #A17, indicated the container of Cidex was dated when opened and was good for 75 days. He/she indicated the mixed solution was good for 28 days, but confirmed the date was not documented anywhere, he/she just remembered it. He/she indicated laryngoscope blades and stylets were soaked in the solution, then rinsed under running tap water for 3 minutes.</p> <p>7. The Toshiba manufacturer's directions for the ultrasound probes indicated, "2. After cleaning, rinse the transducer thoroughly with purified water to remove</p>				

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	<p>all chemical residues. After disinfection, rinse the transducer thoroughly with sterile or deionized water to remove all chemical residues."</p> <p>8. The manufacturer's instructions for the use of Cidex OPA were reviewed. The document indicated under Rinsing Instructions, "a) Following removal from Cidex OPA Solution, thoroughly rinse the semi-critical medical device by immersing it completely in a large volume (e.g. 2 gallons) of water....Keep the device totally immersed for a minimum of 1 minute in duration, unless a longer time is specified by the reusable device manufacturer. ... Remove the device and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing or any other purpose. Repeat the procedure 2 additional times for a total of 3 rinses, with large volumes of fresh water to remove Cidex OPA Solution residues."</p> <p>The document continued under Monitoring of Germicide, "During reuse, it is recommended that the Cidex OPA Solution be tested with Cidex OPA Solution Test Strips prior to each use. This is to ensure that the Minimum Effective Concentration of ortho-phthalaldehyde is present." The directions indicated the mixed solution</p>			

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	<p>should be dated with either a 14 or 28 day expiration, depending on the solution, and discarded after that date even if the test strips indicated it was still effective.</p> <p>9. At 8:55 AM on 06/13/13, staff members #A1 and A16 indicated the facility did not have any additional departmental policies or procedures regarding the use of Cidex and confirmed the facility procedures were not conforming to the manufacturer's instructions.</p>			

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S000598	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iv) Aseptic technique, invasive procedures, and equipment usage. Based on observation and staff interview, the facility failed to ensure the Ultrasound Gel containers are properly disinfected before they were refilled with Liquid Sonic Ultrasound Gel located in the Radiology Ultrasound room.</p> <p>Findings included:</p> <p>1. FDA indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. However, past studies have demonstrated that</p>	S000598	<p>1. Researched the manufacture's literature on ultrasound gel for infections control properties and expiration recommendations. <b>Responsible Person:</b> Director of Supply Chain Completed 7-8-2013 2. Department Directors using ultrasound gel in their areas notified that multi-use containers of gel will be replaced by individual use packets. <b>Responsible Person:</b> Director of Supply Chain Completed 7-8-2013 3. Supply Chain Staff educated on the removal of multi-use gel from department ordering and to only order single use gel packets. <b>Responsible Person:</b> Director of Supply Chain Completed 7-8-2013 4. All multi-use containers of gel removed from facility departments and replaced</p>	07/12/2013			

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	<p>ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA recommends that Ultrasound Gel containers not to be refilled.</p> <p>2. At 10:05 AM on 6/12/2013, the Radiology Department Ultrasound room was inspected. Located in the room was a table with several 16-ounce ultrasound gel containers. On the table were 12 containers to the left of the 3-bottle thermal sonic warming unit. To the right of the warming unit were 29 containers. The containers to the right are filled from a bulk plastic container of Liquid Sonic Ultrasound Gel. The room does not have any sterile processing for the gel containers before they are refilled.</p> <p>3. At 10:10 AM on 6/12/2013, staff member #23 indicated he/she refills the ultrasound jell plastic</p>		<p>with single use packets. <b>Responsible Person:</b> Director of Supply Chain Completed 7-12-2013 <b>5.</b> Monitoring of compliance for only single use gel packets will be sent to the Quality Director Monthly X3 then Quarterly X3. <b>Responsible Person:</b> Director of Supply Chain Data to be sent to Quality beginning with 8-1-2013 data.</p>		

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	bottles without sterilizing and/or disinfecting the containers before they are refilled. The staff member indicated he/she understands the critical necessity of proper disinfecting of the containers or not to refill the containers at all.			

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S000612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on observation and staff interview, the facility failed to ensure the facility's washer fiber mops are washed in a clean and sanitary room.</p> <p>Findings included:</p> <p>1. At 11:15 AM on 6/12/2013, the housekeeping room located in the basement was inspected. The housekeeping room had a washer. The washer was observed with yellow fiber mops in the top-loading washer. Also in the room, there was a sewage lifting</p>	S000612	<p>1. Basement EVS Closet cleaned by EVS Staff Repsonsible Person: Director of EVS Completed 6-12-20132. Discontinue in-house laundering of microfiber mop heads and cleaning clothes. <b>Responsible Person:</b> Director of EVS Completed 6-25-2013 3. Mop Head and Cleaning Cloth policy developed. <b>Responsible Person:</b> Director of EVS Completed 7-12-20134. EVS Staff educated on the new policy and procedure for Mop Head and Cleaning Cloth laundering. <b>Responsible Person:</b> Director of EVS To be completed by 7-31-20135. The laundering of mop heads and cleaning clothes added to the inventory of items to be cleaned by our linen vendor <b>Responsible Person:</b> Director</p>	07/31/2013			

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	<p>station with sewage lines running along the ceiling and the walls. The room was also observed with heavy accumulation of soil residue, spider webs, trash debris, etc throughout the room. The room was observed storing soiled mop heads and recently washed mop heads. The room was not a sanitary room to wash fiber mops that were being utilized by housekeeping for the mopping of patient rooms.</p> <p>2. At 11:22 AM on 6/12/2013, staff member #6 indicated the fiber mop heads are to be used in the patient rooms. The staff member indicated there was concerns of the sanitary environment of the washing of the mop heads and the hospital are looking into the practice.</p>		<p>of EVS Completed 6-25-2013 6. Compliance with the mop head and cleaning cloth process will be monitored daily. <b>Responsible persons:</b> Director of EVS EVS Supervisor – on duty EVS Lead Housekeeper – on duty Monitoring to begin 8-1-20137. Monitoring of compliance of the Mop Head and Cleaning Cloth policy and process will be sent to the Quality Director Monthly X3 then Quarterly X3. <b>Responsible Person:</b> Director of EVS Data to be sent to Quality beginning with 8-1-2013 data</p>		

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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 medical record review, policy and procedure review, training documentation, and interview, the nurse executive failed to ensure assessments were done according to policy for 2 of 2</p>	S000912	<p>1. Emergency Department Assessment and Reassessment Policy reviewed <b>Responsible Person:</b> Director of Emergency Completed 6-13-20132. Pain Management Policy reviewed</p>	07/31/2013			

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	<p>pediatric patients assessed in the Emergency Department (ED) (#N11 and N12).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The medical record for patient #N11, a seven week old who was treated in the ED on 04/03/13, lacked the form "Pediatric Pain Scale". Nursing documentation under vital signs indicated 6/10 using a Wong-Baker (FACES) pain scale.</li> <li>The medical record for patient #N12, an 11 month old who was treated in the ED on 03/14/13, lacked any notation regarding the fontanelles and also lacked the form "Pediatric Pain Scale". Nursing documentation under the triage assessment indicated, "Pain: Unable to use pain scale. Patient is a pre-verbal child." Nursing documentation under vital signs indicated 0/10 using a Wong-Baker (FACES) pain scale.</li> <li>The facility policy "Emergency Dept. Assessment &amp; Reassessment", last reviewed, December 2012, indicated, "3. ...Fontanelles should be noted in infants 12 months and under. ...10. Assessment tools, interventions, medications, and treatments should be based on the pediatric needs."</li> </ol>		<p><b>Responsible Person:</b> Director of Emergency Completed 6-13-2013</p> <p>3. Pain Management Policy revised to include the following:</p> <ol style="list-style-type: none"> <li>3 pain assessment tools and criteria for use the tools are: <ol style="list-style-type: none"> <li>FLACC Scale (Face, Legs, Activity, Cry, Consolability) which is an observational method to be used with patients &lt; 4 years old and any patient unable to self-report</li> <li>Faces Pain Scale which is a self-report method to be used with patients &gt; 4 if developmentally capable.</li> <li>Numeric Rating Scale which is a self-report method to be used with patients &gt;8 years old if developmentally capable.</li> </ol> </li> </ol> <p><b>Responsible Person:</b> VP of Patient Services Completed 7-11-2013</p> <p>4. Pain Management Scales for adults and children laminated and placed in the Emergency rooms</p> <p><b>Responsible Persons:</b> Director of Emergency Completed 7-12-2013</p> <p>5. Re-education of the Emergency Department Assessment and Reassessment Policy and the revision of the Pain Management Policy with the Emergency Department Staff will be completed by July 31, 2012.</p> <p><b>Responsible Person:</b></p>	

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	<p>4. The facility policy, "Pain Management", last reviewed December 2012, indicated, "b. Pediatric or Non-Responsive Adult: 1. Utilize the form 'Pediatric Pain Scale'. 2. Select the appropriate number for each variable under the Cries Pain Scale or Pediatric Objective Pain Scale. 3. Total the corresponding number to appropriate variable. 4. Match number with 'Wong Baker Face Scale'." The policy described the variables to be assessed such as crying, oxygen saturation, increased vital signs, and agitation, based on the infant's age.</p> <p>5. The Mandatory Education 2012 presentation indicated on page 38, "Cries Pain Scale for pre-term to 6 months of age, Pediatric Objective Pain Scale for 6 months through adolescence or non-responsive adult, Pain Assessment Tools- Modified Baker-Wong (Faces Scale)- for use with pediatric patients, ages 3- 18." The educational material described the different variables to assess and how to score them.</p> <p>6. At 2:10 PM on 06/13/13, the ED director, staff member #A7, confirmed the lack of any notation regarding the fontanelles for patient #N12 and indicated the patient was entered incorrectly as a</p>		<p>Director of Emergency To be completed by 7-31-2013 6. Monitoring for Compliance of Emergency Department Assessment and Reassessment and Pain Management in the Pediatric population will be monitored and sent to the Director of Quality Monthly X3 then Quarterly X3. <b>Responsible Person:</b> Director of Emergency Data to be sent to Quality beginning with 8-1-2013 data.</p>		

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	<p>toddler 1- 3 years of age so the infant checks would not have triggered in the electronic medical record. He/she also indicated the staff used the Wong-Baker pain scale for pediatric patients and just recorded a number based on observation and appearance, not by assessing all of the variables and assigning numbers as described in the policy. He/she indicated all of the ED staff had completed the Mandatory Education for 2012.</p> <p>7. At 2:45 PM on 06/13/13, staff member #A1, indicated the Pain Management policy was for both pediatric and adult patients and was the only facility pain policy. He/she confirmed the pediatric assessments in the ED were not according to facility policy and training.</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 facility failed to ensure any person that may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes shall be provided within the work area for immediate emergency use.</p> <p>Findings included:</p> <p>1. Indiana University Bedford Regional Medical Center Environment of Care Manual (Last reviewed November 2012) requires an eye wash station be placed in locations where employees are exposed to corrosive, caustic, and toxic materials for quick flushing of</p>	S001118	<p>1. Eye Wash Station with a 15 minute wash capacity ordered by Plant Operations on 6-13-2013 to install in the basement area within 10 seconds of the Generator Room <b>Responsible Person:</b> Director of Plant Operations Completed 6-21-2013. Education for Plant Operations Staff and EVS Staff of the location and use of the Eye Wash station will be completed by 7-31-2013 <b>Responsible Person:</b> Director of Plant Operations Director of EVS To be completed by 7-31-2013 3. Eye Wash Station added to the facility monthly PM List. <b>Responsible Person:</b> Director of Plant Operations Completed 6-28-2013 4. Monitoring for compliance of monthly PM checks will be sent to the Director of Quality Monthly X3 then Quarterly X3. <b>Responsible Person:</b> Director of Plant Operations Data to be sent to</p>	07/31/2013			

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	<p>eyes with water in case of the eyes come in contact with corrosive, toxic, and caustic materials. The manual also notes that the facility complies with OSHA Safety Standards for employees in the work place.</p> <p>2. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p>		Quality beginning with 7-1-2013 data		

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	<p>3. At 10:00 AM on 6/12/2013, the basement area located near the Generator Room was inspected. The area outside the Generator Room was observed charging two floor walk-behind floor scrubber's batteries. In the Generator Room, there were two Cummins Diesel Generators with 4-12 volt batteries each. Neither the Generator Room nor the room outside the Generator Room where the floor scrubbers were being charged had an eyewash station that meets the 15-minutes of continuous flushing with water if the acid from the batteries splash into an employee's eyes.</p> <p>4. At 10:15 PM on 6/12/2013, staff member #6 indicated the Generator Batteries are checked weekly by the maintenance employees. The staff member indicated there should be an eye wash station in the basement located near the generators and the battery charging system for the floor scrubbers.</p>			

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S001150	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation and interview, the facility failed to ensure the janitor's sink in the housekeeping closet adjacent to the surgical area had a back flow preventer in place.</p> <p>Findings included:</p> <p>1. During the tour of the surgical department at 1:55 PM on 06/12/13, accompanied by staff members #A1, A12, and A26, the sink in the janitor's closet outside of the Ambulatory Care Unit was observed with a metal plate secured in the faucet assembly where a back flow preventer would have been connected. A hose was connected to the faucet and coiled into the sink. Another hose was connected to the disinfectant container and also coiled into the sink. The sink</p>	S001150	<p>1. Work order submitted to Plant Operations on 6-14-2013 to install missing back flow preventor <b>Responsible Person:</b> Director of Plant Operations Completed 6-14-2013 2. Utility Closets placed on monthly PM List to insure back flow preventors remain in place. <b>Responsible Person:</b> Director of Plant Operations Completed 6-28-2013 3. Monitoring for compliance of monthly PM checks will be sent to the Director of Quality Monthly X3 then Quarterly X3. <b>Responsible Person:</b> Director of Plant Operations Data to be sent to Quality beginning with 7-1-2013 data</p>	06/28/2013	

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	<p>was very dirty with sediment and residue on the sides and in the drain. The ends of the hoses were adjacent to the drain and if water/sewage backed up, it could flow into the hoses and into the hospital's water supply.</p> <p>2. At 2:00 PM on 06/12/13, staff member #A26 indicated he/she fills a bucket daily to mop the operating rooms and areas with the hoses and disinfectant in that janitor's closet.</p> <p>3. At 3:45 PM on 06/13/13, staff member #A6 indicated he/she was unaware of this omission and was sure there had been a back flow preventer on that faucet and confirmed that there should be one there.</p>				

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S001172	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation and interview, the facility failed to provide environmental services in the surgical department's janitor's closet to prevent cross contamination to staff and patients.</p> <p>Findings included:</p> <p>1. During the tour of the surgical department at 1:55 PM on 06/12/13, accompanied by staff members #A1, A12, and A26, the following observations were made in the janitor's closet outside of the Ambulatory Care Unit:</p> <p>A. Sink very dirty and stained with particles and residue in the drain and stuck to the sides.</p>	S001172	<p>1. Surgery Department Janitorial Closet cleaned by EVS Staff <b>Responsible Person:</b> Director of EVS Completed 6-12-2013 2. Cleaning of Janitorial Closets added to the duty list of the EVS staff responsible for the specific department <b>Responsible Person:</b> Director of EVS Completed 7-10-2013 3. EVS Staff education on the addition of Janitorial Closet cleaning to their duty lists to be completed by 7-31-2013. <b>Responsible Person:</b> Director of EVS To be completed by 7-31-2013 4. "Janitor closets Clean and in Good Order" Added to the EVS Supervisor's bi-weekly check list. <b>Responsible Person:</b> Director of EVS Completed</p>	07/31/2013

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	<p>B. A black hose connected to the faucet and coiled into the sink.</p> <p>C. A hose connected to the disinfectant and coiled into the sink.</p> <p>D. Soiled cloths wrapped around the faucet handle.</p> <p>E. A bucket with a couple of inches of grayish fluid under the disinfectant hose connection.</p> <p>F. A metal shelf above the sink with a plastic cottage cheese container with kitty litter, a plastic bottle of Sprite soda, and 2 metal spray cans that were stuck to the shelf.</p> <p>G. The floor was very dirty.</p> <p>2. At 2:00 PM on 06/12/13, staff member #A26 indicated he/she fills a bucket daily to mop the operating rooms and areas with the hoses and disinfectant in that janitor's closet.</p> <p>3. At 2:00 PM on 06/12/13, environmental services supervisor, staff member #A13, indicated a contracted company was allowed into that room a while ago, but it didn't look like anyone had been in to clean since then.</p> <p>4. At 10:00 AM on 06/13/13, the director, staff member #A16, indicated the floor care attendant, who was responsible for that area, left 03/15/13 and had not been replaced. He/she indicated</p>		<p>7-10-2013 5 Monitoring of compliance of the Janitorial Closets being cleaned will be sent to the Quality Director Monthly X3 then Quarterly X3. <b>Responsible Person:</b> Director of EVS Data to be sent to Quality beginning with 8-1-2013 data</p>		

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	that area had not been added to the schedule of responsibilities for any other environmental staff member. Staff member #A1 confirmed; however, that the surgical staff member used the room on a daily basis.			