

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150104	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
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NAME OF PROVIDER OR SUPPLIER WITHAM HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2605 N LEBANON ST LEBANON, IN 46052
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 9/29/2014 through 10/1/2014</p> <p>Facility Number: 005093</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 10/28/14</p>	S000000		
S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs</p>			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. During the tour of the surgical department at 1:00 PM on 09/30/14, accompanied by staff member A24, the Director of Perioperative Services, the following observations were made:</p> <p>A. A female surgical staff member was sitting in the break room reading a magazine with a surgical mask hanging around her neck on the front of the scrub top.</p> <p>B. A female staff member walked into the break room with a surgical mask tied and hanging around the back of her neck onto the scrub top, then walked back out again.</p> <p>C. A male staff member (anesthesiologist) came into PACU (post Anesthesia Care Unit), picked up a kit of medication, walked into the operating room suite being set up for a case, then walked back out again with a surgical</p>	S000608	The Clinical Director of Surgical Services has reeducated all staff and physicians on the AORN standards and hospital policy for surgical attire at October and November medical staff and nursing staff meetings. The OR Director has made additional masks available throughout the OR area to enhance compliance. The Director of Infection Control and the Director of Surgical Services will perform random "walk rounds" to ensure compliance. Non-compliance will be managed through the Human Resource disciplinary process for staff members and the medical staff disciplinary process for physicians. The random "walk rounds" will be performed weekly and documented with a monthly report submitted to the Infection Control Committee for 6 months. The Clinical Director of Surgical Services remains accountable to ensure compliance with correction as demonstrated by a monthly report to the Infection Control Committee.	11/05/2014	

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S000952	<p>mask tied and hanging around his neck on the front of his scrub top.</p> <p>2. The facility's policy "Surgical Attire", last reviewed 12/2013, indicated, "All persons entering restricted areas of the surgical suite shall wear a mask, when there are open sterile items and equipment present. Wear single surgical mask in surgical environments where open sterile supplies or scrub persons may be located. A mask will cover both mouth and nose and be secured in a manner that prevents venting. Masks are carefully removed and discarded after use, by handling only the ties. They are not to be saved by hanging around the neck or tucking into pocket for future use."</p> <p>3. At 1:30 PM on 09/30/14, staff member A24 confirmed the facility followed AORN guidelines which also indicated surgical masks should be removed at the completion of each case and not worn around the neck.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in</p>			

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	<p>accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy review, medical record review, and interview, the facility failed to ensure the facility's policy was followed regarding blood transfusions for 5 of 5 patients receiving blood transfusions (N1, N2, N3, N4, and N5).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility's policy "Blood Administration: Blood Component/Platelet/Fresh Frozen Plasma (Includes Blood Transfusion Reaction Protocol)", last revised 07/2013, indicated, "Procedure: ...6. Administration of blood or blood components: ...M. Continue to observe patient every 30 minutes and prn per patient assessment." The medical record for patient N1 indicated a unit of blood was started at 1932 and stopped at 2148 on 07/23/14. Documentation indicated checks were done at 1946, 2000, 2040, and 2148. The medical record for patient N2 	S000952	<p>The blood administration policy has been revised by the CNO to clarify the need to document upon observing any change in the patient's condition during the 30 minute observations. The nursing electronic medical record has been revised to accommodate this change. The open chart review audit has been revised to audit compliance with change. The clinical educator has reeducated all nursing staff who administers blood on the policy change, the EMR changes and revisions to the open chart review form. The Clinical Directors will remain accountable for monitoring and oversight to ensure compliance as demonstrated by a monthly report to the medical records/utilization committee for the next 6 months.</p>	11/10/2014

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	<p>indicated a unit of blood was started at 0117 and stopped at 0408 on 07/31/14. Documentation indicated checks were done at 0132 and 0408.</p> <p>4. The medical record for patient N3 indicated a unit of blood was started at 0023 and stopped at 0252 on 07/09/14. Documentation indicated checks were done at 0036, 0045, and 0250. A second unit was started at 0319 and stopped at 0542 on 07/09/14 and checks were documented at 0328, 0406, and 0541.</p> <p>5. The medical record for patient N4 indicated a unit of blood was started at 0920 and stopped at 1208 on 08/14/14. Documentation indicated checks were done at 0931, 1115, and 1200. A second unit was started at 1401 and stopped at 1627 on 08/15/14 and checks were documented at 1406 and 1627.</p> <p>6. The medical record for patient N5 indicated a unit of blood was started at 0037 and stopped at 0305 on 09/05/14. Documentation indicated checks were done at 0052 and 0304. A second unit was started at 0307 and stopped at 0549 on 09/05/14 and checks were documented at 0318 and 0545.</p> <p>7. At 4:20 PM on 09/30/14, staff member A30, the IT Applications</p>				

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S001118	<p>Manager, who was navigating the electronic medical record, and staff members A6, the Health Information Services Director, and A16, the director of the Intensive Care Unit and Med/Surg Unit, who were in attendance, confirmed the lack of documentation of observations or checks every 30 minutes for patients receiving blood transfusions.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on policy and procedure review, observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in five (5) instances: Witham Health Services at Anson</p>	S001118	The corrective action was set in place by revising the policy. The Supervisor of Plant Operations initiated a revision on the inspection forms for the emergency showers to reflect the weekly inspections. Staff was reeducated on the changes by the Supervisor. Tracking of this success will be Quality Indicators completed monthly and submitted to Safety Committee Quarterly by the Supervisor of Plant Operations The Supervisor of	11/03/2014			

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	<p>Emergency and Laboratory Department offsites and Witham Health Service Hospital's Decontamination Room, Laboratory Department, and Carpentry Shop.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Emergency Eye Wash and Showers policy (last reviewed 1/6/2012) indicated the testing requirements for eye wash and showers complied with American National Standards Institute (ANSI). Centers for Medicare and Medicaid Services considers the guidelines set by such sources as American National Standards Institute (ANSI) proper maintenance and weekly testing is necessary to ensure that Emergency Drench Showers and Eyewash Stations are functioning safely and properly. Weekly testing helps clear the supply lines of sediment and bacteria build-up that 		<p>Plant Operations will continue to monitor the flammables stored in the facility weekly to insure that all have been placed in proper storage. All staff was reeducated on the proper procedure for storage of flammables by the director. Tracking of this process will be recorded monthly and Quality Indicators will be provided to Safety Committee quarterly. The Supervisor of Plant Operations remains accountable for monitoring and oversight to ensure compliance as demonstrated by a report to the respective VP and Safety Committee.</p>	

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	<p>is caused from stagnant water. The ANSI standard states that plumbed flushing equipment, "shall be activated weekly for a period long enough to verify operation and ensure that flushing fluid is available". Furthermore, the ANSI Z358.1-2009 standard also requires Portable and Self Contained equipment "be visually checked to determine if flushing fluid needs to be changed or supplemented".</p> <p>3. At 9:50 AM on 9/30/2014, the Witham Health Services at Anson Emergency Department decontamination room was toured. The decontamination room had an eyewash/shower combo unit. The eyewash was inspected weekly by the department's staff members; however, the shower was inspected monthly by the Maintenance Department. Therefore, the entire combo unit was not tested weekly as required by American National Standards Institute.</p> <p>4. At 10:10 AM on 9/30/2014, the</p>			

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	<p>Witham Health Services at Anson laboratory department was toured. The department had an eyewash/shower combo unit. The eyewash was inspected weekly by the department's staff members; however, the shower was inspected monthly by the Maintenance Department. Therefore, the entire combo unit was not tested weekly as required by American National Standards Institute.</p> <p>5. At 11:30 AM on 9/30/2014, the Witham Health Services Hospital's decontamination room was toured. The room had an eyewash/shower combo unit. The eyewash was inspected weekly by the department's staff members; however, the shower was inspected monthly by the Maintenance Department. Therefore, the entire combo unit was not tested weekly as required by American National Standards Institute.</p> <p>6. At 12:30 PM on 9/30/2014, the Witham Health Services Hospital's</p>			

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	<p>laboratory department was toured. The department had an eyewash/shower combo unit. The eyewash was inspected weekly by the department's staff members; however, the shower was inspected monthly by the Maintenance Department. Therefore, the entire combo unit was not tested weekly as required by American National Standards Institute.</p> <p>7. Hazardous - Hazardous Materials & Waste Storage Practices policy (Last reviewed 2/2012) stated, "Flammable liquids in excess of 10 gallons in any smoke/fire zone are stored in approved flammable liquid storage cabinet, meeting NFPA requirements."</p> <p>8. At 1:15 PM on 9/30/2014, the Carpentry Shop was observed with a skid of eight cases of 4-gallons each case of oil based Rust-Oleum. There were 8 loose gallons of Rust-Oleum observed either on the cases or stored to the side of the</p>			

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S001125	<p>cases. The loose gallons and the top four cases of the Rust-Oleum were observed with heavy accumulation of dirt debris on them. The loose gallons were also observed with a box of binders and other miscellaneous items stored on them which gave the appearance of the skid was stored in the same location for a lengthy period of time.</p> <p>9. At 10:00 AM on 10/1/2014, staff member #10, Plant Operations, indicated the amount of Rust-Oleum exceeded the amount of flammable material that can be stored outside a flammable cabinet.</p>				

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	<p>PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(B)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(B) Operational and maintenance control records shall be established and analyzed periodically. These records shall be readily available on the premises.</p> <p>Based on policy and procedure review and staff interview, the hospital failed to provide documented evidence of weekly inspections of the emergency generator.</p> <p>Findings included:</p> <p>1. Electrical Distribution Systems: Preventive Maintenance policy (Last reviewed 2/2012) indicated the tests are documented to assure the generator is performing in a reliable manner. The policy had</p>	S001125	The Supervisor of Plant Operations has initiated a new check-off form that supports visual inspection of the generator weekly. Tracking of compliance will be monitored monthly by the Supervisor of Plant Operations with Quality Indicators provided to Safety Committee quarterly. The Supervisor of Plant Operations remains accountable for monitoring and oversight to ensure compliance as demonstrated by a report to the respective VP and Safety Committee.	11/10/2014	

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	<p>attached the Weekly Generator Inspection Sheet. The weekly inspection sheet included: who inspected the generator; documented visual inspections of Lubricating Systems, Cooling System, Fuel System, Air System, Charging System.</p> <p>2. NFPA 110, 1999 edition Chapter 6, Operational Inspection and Testing indicated Emergency and Standby Power Systems, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. A written record of the Emergency and Standby Power Systems inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: The date of the maintenance report; Identification of the servicing personnel; Notation of any unsatisfactory condition and the corrective action taken, including parts replaced;</p>			

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	<p>and testing of any repair for the appropriate time as recommended by the manufacturer.</p> <p>3. The preventive maintenance inspection logs of the generator were reviewed with staff member #10, Plant Operations. The generator logs evidenced monthly, semi-annual, and annual inspections. Weekly inspection logs of the generator were not provided during the survey.</p> <p>4. At 10:00 AM on 9/30/2014, staff member #10, Plant Operations, indicated the Maintenance Department does not document weekly preventive maintenance inspections of the generator because maintenance-free batteries are used. However, after the staff member read the policy on generator preventive maintenance inspections, the staff member confirmed weekly preventive maintenance inspections were not documented as per policy.</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 interview and document review, the facility failed to ensure environmental services were provided at their off-site in a manner that ensured the prevention of transmission of disease to staff and patients.</p> <p>Findings included:</p> <p>1. While on the tour of the ED (Emergency Department) at the facility's off-site at 9:20 AM on 09/30/14, accompanied by staff members A1, the</p>	S001172	The VP of HR reeducated the Supervisor of Environmental services on the policy regarding use of contracted employees and developed a new form that outlines the specific requirements for contracted environmental services employees. All on site contracted staff files have been reviewed for appropriate documentation of orientation and annual training by the Supervisor of Environmental Services. The Supervisor of Environmental Services has identified to all contractors the need to provide	11/10/2014

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	<p>COO, and A19, the ED Director, staff member A19 indicated a contracted cleaning service came into the department daily after 3:00 PM to perform the routine cleaning. He/she indicated he/she did not observe the staff and was not involved in any training for them. Staff member A1 indicated any contracted services were under the specific department director of the main hospital, such as this contracted cleaning service was under the main hospital's environmental services director.</p> <p>2. When orientation, annual inservicing, and health records for the contracted cleaning staff was requested, a binder was provided which contained initial orientation for approximately 16 different staff members. Despite earlier hire dates, most of the staff received initial orientation in May of 2012 with all new staff receiving orientation upon hire. The binder lacked any further annual education or any health and immunization information.</p> <p>3. At 2:05 PM on 09/30/14, staff member A15, the Environmental Services Coordinator, brought documentation from 07/14/14, and indicated he/she observed the cleaning staff and asked the staff questions to ensure services were performed</p>		<p>orientation and annual training based on standards set by Witham. Ongoing compliance will be monitored by the Supervisor and VP of HR and validated by requests to view actual documentation each month with any new staff that take an assignment at Witham. Using this collected data a monthly report will be compiled and submitted to the Quality Council for the next 6 months. The Supervisor of Environmental Services remains accountable for monitoring and oversight to ensure compliance as demonstrated by a report to the respective VP and Quality Council.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150104	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014
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	<p>according to expectations.</p> <p>4. At 12:05 PM on 10/01/14, staff member A15 indicated the observation sheet that was provided yesterday was the only additional training provided to the off-site cleaning staff. He/she indicated he/she did not have documentation of annual inservicing or health records.</p>				