STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150157	A. BUILDING 00 B. WING	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT CARMEL HOSPITAL INC	13500 N MERIDIAN ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	This visit was for a State hospital licensure survey. Dates: 1/23/2012 thru 1/25/2012 Facility Number: 003932 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 02/14/12	S0000		

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

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

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S0554	410 IAC 15-1.5-2 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 observation, review of manufacturing labeling, policy review, and interview, the facility failed to ensure all patient care areas were maintained in a clean, sanitary manner and manufacturer's directions were followed regarding storage of tube feedings and dating and discarding of supplies. Findings included: 1. During the tour of the Medical/Surgical Unit at 10:50 AM on 01/24/12, accompanied by staff members #P2 and P15, the following observations were made: A. The crash cart and suction machine were soiled with a layer of dust. B. The ledges in the patient restrooms were dusty. C. Two 1200 milliliter containers of Jevity tube feeding were stored on an open shelf in the nourishment room. The instructions on the label indicated the solution contained light sensitive nutrients.	S0554	1. Department and associate responsibilities clarified (includes thermometer holders, trash cans, nurses stations, wall suction canisters, fire extinguishers, Sanimaster expiration/replacement, and ledges) Feb 21, 2012. All associates to be re-educated concerning cleaning responsibilities. Due to volume of associates to be trained, training will be completed Mar 15, 2012.2. All Crash Carts cleaned and covers ordered. Policy amended to include covering of the cart and replacement of cart cover as needed. Covers on backorder and will be in place by Mar 15, 2012.2. All cart bottoms inspected and cleaned throughout facility. Items placed on a weekly cleaning schedule.4. Housekeeping policy “Room cleaning other than patient rooms” reviewed for clarity and expectations and re-educated to housekeeping associates. 5. Cidex use eliminated in the Obstetrical area. Endoscopy policy changed to reflect manufacturer’s recommendation and reeducated. Due to volume	02/25/2012

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	2. During the tour of the Orthopedic Unit at 11:20 AM on 01/24/12, accompanied by staff members #P2 and P15, the following observations were made: A. A spray bottle of SaniMaster 4 disinfectant, with an expiration date of 12/06/11, was on a stand in the clean utility room where an overflowing trash can was also observed. B. The wall mounted holders for the thermometer devices were soiled with a layer of dust. C. The back areas of the nurses' station desk were soiled with a layer of dust. 3. During the tour of the Surgical Department at 10:20 AM on 01/25/12, accompanied by staff members #P2, P5, P17, and P18, the following observations were made: A. The bottoms of the patient carts were soiled with a layer of dust. B. The crash carts, suction machines, and defibrillators were soiled with a layer of dust. C. The wall suction canisters in the pediatric recovery room were soiled with a layer of dust. D. The wall mounted fire extinguisher in the recovery room was soiled with a layer of dust.		of associates to be trained, training will be completed Mar 15, 2012.6. Environmental cleanliness to be monitored on Environment of Care Rounds and reported to Department directors.	

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	4. During the tour of the Emergency Department at 10:55 AM on 01/25/12, accompanied by staff members #P2, P5, P22, and P23, the following observations were made: A. The wall ledges and bottom of the cart in room #16 were soiled with a layer of dust. B. The crash cart, suction canister, and defibrillator in the hallway were soiled with a layer of dust. 5. During the tour of the Obstetrical Department at 11:25 AM on 01/25/12, accompanied by staff members #P2, P5, and P24, the following observations were made: A. The crash cart, suction canister, and defibrillator were soiled with a layer of dust. B. The Cidex OPA test strips were dated as opened 05/13/11 and discard 09/13/11. The manufacturer's directions were to discard 90 days after opening. 6. During the tour of the Endoscopic cleaning room at 12:20 PM on 01/25/12, accompanied by staff members #P2, P5, and P26, the following observation was made: A. Cidex OPA test strips were dated as opened 12/06/11 and discard 03/06/11. The manufacturer's directions were to discard 90 days after opening.			

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	7. The facility policy titled "Room Cleaning Other Than Patient Rooms, approved 07/2011, indicated, "...Order of Cleaning- 1. Empty and sanitize wastebaskets 2. High dust 3. Damp wipe furniture, ledges, etc. 4. Spot clean switches, walls, doors 5. Microfiber clean/vacuum floor." The document continued, "...Damp wipe furniture- Start as door, work systematically around the room (counter clockwise). a. equipment, (other than medical equipment) b. ledges and counters c. phone." 8. At 11:15 AM on 01/24/12, housekeeping staff member #P16 indicated the patient rooms were the top priority regarding cleaning and the other areas of the unit were cleaned when there was time. He/she indicated there was also a second shift cleaning staff that worked on the unit and maybe they were able to do more cleaning of the rest of the unit.			

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S0596	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (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: (iii) Cleaning, disinfection, and sterilization. Based on observation, document review, and staff interview, the facility failed to ensure hospital staff utilize personnel protective equipment (PPE) for chemical Cidex OPA when handled and ensure the Cidex OPA test strip container's lid was tight fitting as required by the manufacturer for the Radiology Department and failed to ensure policies and procedures were in place and followed for the disinfection of instruments in the Obstetrical (OB) and Endoscopy departments. Findings included: 1. The hospital was using Ortho-phthalaldehyde Solution (Cidex	S0596	1. Gluteraldyde use discontinued in the OB department. Vaginal probes will be bagged and transported to Radiology for disinfection.2. Radiology and Endoscopy procedures updated and reeducated to staff to reflect manufacture's recommendation. Special emphasis placed on appropriate PPE, closing and use of test strips, and rinsing after disinfection. Due to volume of associates to be educated, training will be complete by Mar 15, 2012.4. Radiology and Endoscopy departments to conduct monthly audit to monitor compliance.	02/25/2012

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	OPA), high level disinfectant for semi-critical devices, in the Radiology Department for the Ultrasound. Cidex OPA manufacture sheet requires use PPE when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns and the lids for the test strips and solution need to be tight fitting. 2. At 10:00 AM on 1/25/2012, the Radiology Department was toured. The test strips for the Cidex OPA were inspected and the container was properly date marked. However, the lid to the test strips were open. The Ultrasound room where the Cidex OPA was handled contained no fluid resistant gowns and goggles. 3. Staff member A10 explained the handling of Cidex OPA. At 10:05 AM on 1/25/2012, the staff member indicated he/she uses gloves when handling Cidex OPA; however, goggles and a fluid resistant gown are not utilized. The staff member indicated he/she did not know that a fluid resistant gown and goggles are also to be worn when handling Cidex OPA. 4. During the tour of the OB department at 12:15 PM on 01/25/12, accompanied by staff members #P2, P5, and P24, a sign on the wall in the soiled room indicated			

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	Metricide OPA solution was now being used instead of Cidex OPA; however, Cidex OPA test strips, with an outdated use date of 09/13/11, were on the counter. Staff member #P24 indicated the disinfectant was used for the vaginal probes and he/she thought it was done in the C/S rooms. There were no instructions for the process and the soiled room did not contain a sink for any cleaning or rinsing. 5. During the tour of the soiled room of the Endoscopy unit at 12:20 PM on 01/25/12, accompanied by staff members #P2, P5, and P26, a plastic container labeled with Cidex OPA was observed on the counter. Staff member #P26 indicated instruments were soaked in the container then rinsed in sterile water in a different container. A procedure taped on the wall of the room indicated the rinsing should be done in the sink, but was not specific as to the actual steps of the process. 6. Review of the facility's disinfecting policies failed to indicate policies and procedures for the use of Cidex OPA or Metricide OPA. 7. Manufacturer's directions for the use of Cidex OPA indicated, "...6. Rinse Instruments- Following disinfection, rinse instruments thoroughly flushing the			

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	channels with potable or sterile water. Be sure to repeat this procedure twice, for a total of three rinses. Each rinse should be a minimum of one minute in duration, and a large volume of fresh water (e.g. two gallons) must be used for each rinse." 8. Manufacturer's directions for the use of Metricide OPA indicated, "...4. Using test strips and logging data- The concentration of your Metricide OPA Plus Solution must be verified by a Metricide OPA Plus Solution Test Strip prior to each use to guard against dilution that may lower the orth-Phthalaldehyde level of the solution below its MRC. ...6. Rinsing Instruments- After manual processing- After removing the instrument from the Metricide OPA Plus Solution, thoroughly rinse the device by immersing it completely in a large volume (approx. 9 liters) of fresh water. ...Keep the instrument totally immersed for a minimum of one minute unless a longer time is specified by the instrument manufacturer. ...Repeat the procedure two additional times for a total of three rinses." 9. At 4:00 PM on 01/25/12, staff members #P1 and P2 confirmed the lack of policies and procedures for disinfecting instruments with Cidex OPA and Metricide OPA.			

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S0610	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (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: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation and document review, the facility failed to ensure kitchen staff are washing hands as required by Retail Food Establishment Sanitation Requirements and hospital policies for St. Vincent Carmel Hospital's Kitchen/cafeteria. Findings included:	S0610	1. New policy, "Safe Food Handling and Personal Hygiene Practices" written based on cited 410 IAC 7-24-129.2. Policy distributed to all Food Services personnel and acknowledgement statement collected. Due to volume of associates and work schedules, acknowledgement statements will be collected by Mar 15, 2012.3. In person education provided to all Food	02/25/2012

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	1. Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-129, When to Wash Hands states, "Food employees shall clean their hands and exposed portions of their arms as specified under section 106 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: After touching bare human body parts other than clean hands and clean, exposed portions of arms; After using the toilet room; After caring for or handling service animals or aquatic animals as specified in section 116(b) of this rule; After coughing, sneezing, or using a handkerchief or disposable tissue; After drinking, other than as specified in section 113(b) of this rule, using tobacco, or eating; After handling soiled surfaces, equipment, or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with raw food and working with ready-to-eat food; Before touching food or food-contact surfaces; Before placing gloves on hands; and after engaging in other activities that contaminate the hands**."** 2. Food Handling policy #177924 states,		Services personnel. Due to a variety of work schedules, edcuation will be completed by Mar 15, 2012.4. Hand hygiene observations will be conducted on a monthly basis to monitor compliance.	

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	"Appropriate personnel are trained regarding general sanitation theory, use and cleaning of equipment, personnel hygiene, etc. Appropriate personnel are trained regarding sanitary food handling procedures." 3. The employee dietary handbook stated, "Training pertaining to good handwashing technique is provided to all associates. Training includes the following information: Hands must be washed when beginning work and before and after handling contaminated equipment or materials; Hands must be washed between the handling of soiled dishes and clean dishes; Hands must be washed between the handling of cooked and uncooked food. Vinyl gloves are worn under the circumstances listed: Gloves are worn when handling ready to eat food; Gloves are changed immediately when they become contaminated or torn; Gloves are worn on clean hands only." 4. Each hospital dietary employee has an Associate Orientation Checklist made part of their training packet. Each hospital dietary employee evidenced of receiving a dietary handbook as stated on their Associate Orientation Checklist. 5. At 10:45 AM on 1/23/2012, the hospital kitchen/cafeteria were toured.			

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	The two staff behind the grill station serving line were observed changing their gloves routinely without washing their hands first. The staff member behind the entrée serving line was observed cleaning the counter with a rag and gloved hands and then set the rag under the counter and began to serve customers from the steam counter without changing gloves and washing hands first. When the staff member did change his/her gloves, the staff member failed to wash the hands first before changing of gloves. While touring the kitchen, three staff members in the kitchen were observed changing their gloves without washing their hands first. 6. At 10:45 AM on 1/23/2012, the Gelato Da Vinci bistro kitchen were toured. The two staff behind the grill station serving line were observed changing their gloves routinely without washing their hands first. The staff member behind the entrée serving line was observed cleaning the counter with a rag and her gloved hands and then sat the rag under the counter and began to serve customers from the steam counter without changing gloves and washing hands first. When the staff member did change gloves, the staff member failed to wash hands first before changing of gloves. While touring the kitchen, three staff members in the			

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	kitchen were observed changing their gloves without washing their hands first.			

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S1124	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A) (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: (5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows: (A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment. Based on document review and staff interview, the facility failed to perform periodic preventive maintenance inspections on the Hydrocollator as specified by the manufacturer's recommendations. Findings included: 1. The instructions for the use and operation of the Hydrocollator M-1 Master Heating Unit states, "The thermostat is extremely sensitive and the	S1124	1. Callibration procedure reeducated to all biomedical equipment technicians. 2. Daily log changed to reflect manufacturer's temperature specifications and will be monitored monthly to ensure compliance.3. Annual Preventative Maintainence has been performed and scheduled annually for this device.	02/25/2012

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT CARMEL HOSPITAL INC	13500 N MERIDIAN ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	slightest adjustment will alter the temperature several degrees. The recommended operating temperature is 160 to 166 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs." 2. The Hydrocollator Temp Log was reviewed. The log notes, "If temperature above 180 or below 160 document corrective action below." The temperature log was in conflict with the manufacturer's temperature requirements of the temperature range 160 to 166 degrees Fahrenheit. The recorded temperatures for the first 22 days of January 2012 were between 174 and 176 degrees Fahrenheit. 3. The Hydrocollator was removed from the Rehab Department on 1/25/2012. At 9:30 AM on 1/25/2012, staff member AD1 indicated the Hydrocollator thermometer the staff uses was checked for correct calibration and it was discovered the thermometer was within acceptable range of being off calibration no more than 2 degrees Fahrenheit. The staff member indicated he/she does not no where the hospital got the range of 160 to 180 degrees Fahrenheit when it would be violating the manufacturer's required temperature range. The staff member indicated the hospital staff are to take			

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	daily temperatures of the Hydrocollator.			

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S1125	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(B) (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: (5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows: (B) Operational and maintenance control records shall be established and analyzed periodically. These records shall be readily available on the premises. Based on staff interview, the facility failed to provide documentation of preventive maintenance on the floor scrubbers utilized in the hospital. Findings included: 1. Preventive Maintenance policy #63072 states, "The purpose of the euipment preventive maintenance program is to identify problems, maintain efficient operating and reliability, improve performance and assure the safety of hospital, patient care equipment, physical plant, grounds equipment and life and operationsl support systems. All	S1125	1. Inventory of floor scrubbers completed. 2. Each machine to be placed through preventative maintainence process. This will be completed by Mar 9, 2012 (due to outside vendor performing) and annually.	02/25/2012

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	equipment entered into the preventive maintenace program is at the request of the associate responsible for the equipment using the guidelines set in the Statement of Preventive Maintance. All paper equipment records for the equipment will be kept in the Facility Services office." 2. At 2:30 PM on 1.23.2012 and 12:00 PM on 1/24/2012, staff member AD6 was asked for documentation of preventive maintenance on the hospital's floor scrubbers. At 2:30 PM on 1/23/2012, staff member AD6 indicated the floor scrubbers are owned by the contracted housekeeping staff and the documentation has to be obtained from them. The contracted staff has an office and storage rooms in the basement of the hospital. The staff member indicated the floor scrubbers and other maintenance equipment are not made part of the hospital risk base assessment. The staff member did not provide documentation of preventive maintenance on the floor scrubbers during 1/23/2012 through 1/25/2012.			

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S2104	410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8(a) (a) If the hospital provides inpatient or ambulatory surgical services, the services shall meet the needs of the patients served, within the scope of the service offered, and in accordance with acceptable standards of practice and and safety. Based on observation, policy review, and interview, the facility failed to ensure a policy and training were in place to ensure staff response for the surgical emergency of malignant hyperthermia (MH). Findings included: 1. During the tour of the Obstetrical Department (OB) at 11:25 AM on 01/25/12, accompanied by staff members #P2, P5, and P24, no malignant hyperthermia kit or cart was observed for the two operating rooms used for C-sections. Staff member #P24 indicated the necessary medication, Dantrolene, was in the Pixis pharmacy system on the unit, but when he/she checked, there was none of this medication on the unit. Staff member #P24 indicated he/she would contact the pharmacy and thought the other supplies were in the surgery department. He/she indicated there was no annual training for staff on malignant	S2104	1. Small work group formed to develop policy and write/research education plan. Draft policy written and appoved by group. Education plan designed and ready for implementation.2. New hospital policy "Code Malignant Hyperthermia" approved Mar 1, 2012 due to length of hospital policy approval process.3. Obstetrical services associates completed mandatory education on Malignant Hyperthermia (Web based training) and read new policy with signed acknowledgement statement returned. Due to volume of staff and variety of schedules, education to be completed by Mar 15, 2012.4. Surgical Services associates received new policy with signed acknowledgement statement returned. Due to volume of staff and variety of schedules, acknowledgement statements will be completed by Mar 15, 2012.5. Malignant Hyperthermia education made an annual requirement for affected associates. Affected associates annual education records to be	02/25/2012

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	hyperthermia. At 12:10 PM on 01/25/12 while on the OB unit, staff asked the anesthesiologist, staff member #P25, about where medication and equipment for MH was located. Staff member #P25 indicated he/she would ask the pharmacy department. 2. Review of the facility's policies and procedures failed to indicated any for the surgical emergency of malignant hyperthermia. 3. At 1:10 PM on 01/25/12, the pharmacy director, staff member #P14, indicated 24 vials of Dantrolene were kept in the surgery department and another 24 vials were kept in the pharmacy to be taken to surgery or OB in case of an emergency. 4. At 3:45 PM on 01/25/12, staff member #P1 indicated the MH cart with supplies, along with 24 vials of Dantrolene, was located in the surgical department and would be taken to the OB department in the event of an emergency. He/she also provided a copy of an educational presentation on MH that was part of an OR Critical Events training session from 08/03/11. This session was attended by OR staff, but not OB staff. Staff members #P1 and P2 confirmed the		audited for compliance.	

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	training was not provided to all surgical staff nor was it specific regarding where all necessary supplies and medication were located and how they were to be acquired.			