

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/10/2013
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NAME OF PROVIDER OR SUPPLIER  MARION GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 441 N WABASH AVE MARION, IN 46952
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S000000	The visit was for a licensure survey.  Facility Number: 005011  Survey Date: 7-08-13 to 7-10-13  Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor  Linda Plummer, RN Public Health Nurse Surveyor  Steve Poore, BS MLT Medical Surveyor 3  QA: claughlin 07/18/13	S000000		
S000102	410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)  (a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on personnel file review, document review, and interview, the facility failed to ensure that state rules and regulations were complied with in reference to IC 16-28-13 for 2 of 2 student nurse files reviewed (staff	S000102	<b>S 102: 1 &amp; 21.</b> How are you going to correct the deficiency? If already, corrected, include the steps taken and the date of the correction. <b>The Indiana Online Licensing checks were run for the two (2) student nurses the</b>	07/27/2013

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>members #25 and #27).</p> <p>Findings:</p> <p>1. at 12:30 PM on 7/9/13, review of IC 16-28-13-4 with staff member #60, the administrative director of human resources, indicated that:</p> <p>a. "Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or (2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility; shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 10-13-3 or another source by law."</p> <p>2. at 12:00 PM on 7/9/13, review of two student nurse personnel files, both hired 12/12, indicated the nurse aide registry was not contacted for a report, as required by IC 16-28-13-4</p> <p>3. interview with staff member #60 at 12:30 PM on 7/9/13 indicated:</p> <p>a. staffing in the human resources department has changed and it is not</p>		<p><b>day the surveyors were here (7/9/13). These Indiana Online Licensing checks were printed and provided to the surveyor. This deficiency was corrected on 7/9/13.</b></p> <p>2. How are you going to prevent the deficiency from recurring in the future? <b>The Indiana Online Licensing check is now a required step in the on-boarding process for all new MGH employees, regardless of the position for which they are hired. The Indiana Online Licensing check is now a required field on the on-boarding "check off" list for all new employees (Line item #5, "Verification of Licensure"). A copy of the Online Licensing check will be printed for each employee prior to on-boarding and placed into their personnel file. In the event the Online Licensing check comes back with no results found, the name of the employee will be handwritten on the printed copy of the results and placed in the employee's personnel file. In addition, the Employment Coordinator completed a retroactive check on all MGH employees hired as of 12/5/11 to ensure all required employees are captured. This was completed on 7/27/13.</b></p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? <b>The</b></p>		

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S000318	<p>known if staff are fully aware that the registry check needs to be done and how to document this</p> <p>b. there is no policy related to checking the nurse aide registry for unlicensed care givers, but it is on the human resources new employee checklist of things to do at the time of hire</p> <p>c. it was unknown that student nurses needed the registry check completed, as well as with other newly hired nurse aides</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review, credential</p>	S000318	<p><b>Employment Coordinator will be responsible for correcting the deficiency as well as preventing the deficiency from recurring in the future. The Employment Relations Manager and Administrative Director of Human Resources will make sure the Employment Coordinator follows this new process of checking the Indiana Online Licensing for all MGH employees. In addition, all Indiana Online Licensing documents will be audited when personnel files are scanned. 4. By what date are you going to have the deficiency corrected? 7/9/13</b></p>	07/25/2013			

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	<p>file review and interview, the facility lacked documentation of medical staff cardiopulmonary resuscitation (CPR) competency for 6 of 9 credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The Medical Staff Bylaws (board approved 8-12) failed to require CPR competency for all medical staff who provide direct patient care and failed to indicate physicians exempted from the State rule 410 IAC 15-1.4-(c)(6)(F) by training or experience.</li> <li>2. Review of 6 medical staff credential files (a general surgeon, a dentist, a pulmonologist, a radiologist, a rehabilitation physician and an urologist) lacked documentation of current CPR competency.</li> <li>3. During an interview on 7-09-13 at 1245 hours, staff A2 confirmed that the medical staff bylaws lacked a CPR competency requirement for credentialed medical staff.</li> <li>4. During an interview on 7-09-13 at 1255 hours, staff A2 confirmed that 6 of 9 credentialed medical staff files lacked documentation of CPR competency and no additional documentation was</li> </ol>		<p>to correct the deficiency? If already corrected, include the steps taken and the date of correction. Unfortunately Medical Staff Policy MEC-225 was not provided at time of survey. Policy was uploaded to the ISDH Survey site but was not viewable by the ISDH, policy was emailed on 8/22/13. Our Medical Staff Policy MEC-225 reads as follows in its entirety: [All Active Medical Staff Members are encouraged to participate in Cardiopulmonary Resuscitation Training. Physicians who provide direct patient care such as Anesthesiologists and Emergency Department Physicians are required to maintain and provide documentation at a minimum of current BLS/CPR (Basic Life Support/Cardiopulmonary Resuscitation) certification, as noted in the individual physician's delineation of privileges. Competency will be monitored and evaluated during the required BLS/CPR certification or recertification courses. Each individual physician shall be required to provide proof of the BLS/CPR certification to the Hospital Medical Staff Office for tracking.] 2. How are you going to prevent the deficiency from recurring in the future? Medical Staff Office will monitor proof of BLS/CPR by physician. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? President/CEO</p>		

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S000394	<p>available.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 5 contracted services.</p> <p>Findings:</p> <p>1. On 7-08-13 at 1730 hours, four lists of contracted services (maintenance contracts, biomedical equipment contractors, environmental services contracts, and a Service Contract listing) was received from staff A5. The list of maintenance contracts lacked a current service provider for 3 fire services (extinguishers, fire pumps and sprinkler maintenance and certification) and the</p>	S000394	<p>and Medical Staff leadership. 4. By what date are you going to have the deficiency corrected? Policy was uploaded to ISDH in July but was sent email on 8/22/13.</p> <p><b>S394: 1-31.</b> How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · The list of contracted services spreadsheet was updated July 12, 2013 to include the applicable information on the fire extinguishers, fire pumps, sprinklers, gamma camera, and medical physics service vendors.</p> <p>2. How are you going to prevent the deficiency from recurring in the future? · The contracted services spreadsheet will be reviewed quarterly in the Environment of Care meeting. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? · Administrative Director of Plant Operations and Safety Officer 4.</p>	07/12/2013			

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S000406	<p>list of biomedical equipment services failed to indicate a service provider for gamma camera service and a medical physics service.</p> <p>2. Review of facility documentation indicated the following: fire extinguisher service by CS1, fire pump service by CS2, fire sprinkler service by CS3, gamma camera service by CS4, and medical physics by CS5.</p> <p>3. On 7-10-13 at 1115 hours, staff A6 confirmed that the list of contracted services had not been maintained.</p> <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. Based on document review and interview, the facility failed to follow its policy/procedure and ensure that its contracted services were monitored and</p>	S000406	<p>By what date are you going to have the deficiency corrected? · Completed July 12, 2013</p> <p>S 406: 1-4 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. We</p>	07/25/2013

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	<p>evaluated through its Performance Improvement (PI) program for 10 services.</p> <p>Findings:</p> <p>1. The Performance Improvement Plan (revised 6-12) indicated the following: " VI. Improvement. All decisions to undertake improvements in processes or creation of new processes are based on data assessment which includes ...evaluation of services, including services provided by a contractor. "</p> <p>2. PI program documentation failed to indicate 6 radiology equipment service providers (cath lab, computerized tomography [CT], gamma camera, magnetic resonance imaging [MRI], mobile x-ray and medical physics), 3 fire prevention services (alarm monitoring and system certification, fire extinguishers and fire sprinkler maintenance and certification) and a generator service were evaluated and reviewed through the PI program.</p> <p>3. On 7-08-13 at 1355 hours, staff A8 confirmed that the radiology contractors were not being reviewed through the PI program.</p> <p>4. On 7-10-13 at 1115 hours, staff A6</p>		<p>added the items suggested in Finding #2 to our "Performance Improvement Measures by Department" report, which goes to the Medical Executive Committee and the Board Quality Care &amp; Patient Safety Committee.</p> <p>2. How are you going to prevent the deficiency from recurring in the future? The items added will remain on the "Performance Improvement Measures by Department" report from this point forward. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? Director of Plant Operations 4. By what date are you going to have the deficiency corrected? 07/25/2013</p>				

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S000556	<p>confirmed that the fire and generator service contractors were not being reviewed through the PI program.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the infection control committee failed in its effectiveness related to follow up from positive culture reports of the IV (intravenous) room at the oncology center.</p> <p>Findings: 1. at 3:35 PM on 7/8/13, review of the 2012 and 2013 Infection Control Committee meeting minutes indicated: a. at the August 22, 2012 meeting a report was given that read: "We had some positive cultures come back from Oncology Center. They are all within standards, but had cultures come back positive. There was one positive colony found in the clean room." b. in the "Action" section of the</p>	S000556	<p>S 556: 1-2</p> <p><b>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</b></p> <p>The follow-up information for action items 1 a-c and 2a-c will be shared with the Infection Control Committee at the next scheduled meeting August 28, 2013</p> <p>Construction on the third clean room for the hoods was completed on July 28, 2013. A change was made in October of 2012 to use Dispatch to clean the area; pharmacy staff is maintaining a log of each cleaning. Environmental cultures in the IV room were completed on November 9, 2012 and May 28, 2013. Ongoing testing</p>	08/28/2013

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	<p>minutes, it read: "We will culture I.V. (intravenous) rooms periodically. We have proposed building a third room that would be the clean room for the hoods in the Oncology area. He (unknown who this person is) suggested switching to Dispatch to do cleaning in this area. Retesting in September to see if changes are helping us get bacteria under control."</p> <p>c. review of the October 24, 2012, December 19, 2012, February 27, 2013, and April 24, 2013 meeting minutes failed to indicate that any further follow up or discussions occurred related to: periodic culturing of IV rooms, whether a third room was built as suggested, if Dispatch is currently being used and was approved by the committee, whether retesting was performed in September and what the results were.</p> <p>2. interview with staff member #61, the infection preventionist, at 2:00 PM on 7/9/13 indicated:</p> <p>a. there is no documented follow up to the discussion presented at the August 22, 2012 meeting related to positive cultures found in the IV room at the oncology center</p> <p>b. a more recent meeting was held in June and the minutes are not yet available, but this topic was not on the agenda for that meeting either</p>		<p>is set up by plant engineering and the pharmacy and is scheduled to continue biannually. All tests including those mentioned in the meeting on August 22, 2012 have been within the guidelines set by USP 797.</p> <p><b>2. How are you going to prevent the deficiency from recurring in the future?</b></p> <p>To ensure that agenda action items are followed up on in the future, the agenda will include previous meeting minutes for approval. Old business will be added as an action item on every IC agenda going forward to include follow up on open items i.e. updated status of items outlined in # 1a-c and #2a-c.</p> <p><b>3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)?</b></p> <p>The Infection Control Coordinator</p> <p><b>4. By what date are you going to have the deficiency corrected?</b></p> <p>All future agenda action items will be reported in the meeting to follow in the (newly created) old business section of the agenda.</p>		

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S000606	<p>c. the infection control committee does not have a method in place to alert the committee to old business that was to be followed up on and brought back for discussion, especially related to the issue listed in 1 above</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on policy and procedure review, personnel file review, and staff interview, the infection control committee failed to ensure the implementation of its policy related to immunization status for 3 of 4 contracted dietary staff (staff #40, #42, and #43), and for 2 of 2 contracted EVS (environmental services-housekeeping)</p>	S000606	<b>S 606: 1-81. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · Contracted dietary staff #40, #42, and #43 health files have been corrected and contain all proper immunization documentation for Rubella, Rubeola, Measles, Mumps, and</b>	08/30/2013

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	<p>employees (staff #44 and #45) and failed to evaluate and monitor compliance for personnel immunity to communicable diseases (rubella, rubeola, varicella and hepatitis B) for 3 (A21, A22, A23) of 9 staff files reviewed.</p> <p>Findings:</p> <p>1. at 8:30 AM on 7/9/13, review of the policy and procedure "Rubella, Measles, Mumps, Varicella", policy number "IFC-922" with a revised date of 6/26/13, indicated:</p> <p>a. under "Purpose", it reads: "All healthcare facilities should ensure that those who work in their facilities are immune to measles, mumps, rubella and Varicella. All employees, employed physicians and volunteers must show evidence of immunity. Contract Staff (i.e., Morrison, Crothall) must also show proof of immunity..."</p> <p>2. at 12:20 PM on 7/9/13, review of dietary personnel health files indicated:</p> <p>a. staff member # 40, the executive chef, was lacking any documentation of immunity to Varicella</p> <p>b. staff member #42:</p> <p>A. had a self/parent reported note from a physician's office that lacked the authentication by the practitioner of the employiye having had Varicella</p> <p>B. lacked documentation of</p>		<p><b>Varicella. The contract staff immunity titers were drawn and results of immunity were put into files by 7/24/13. · Contracted EVS/housekeeping staff #44, #45, A22, and A23 health files have been corrected and contain all proper documentation for immunity to rubella, rubeola, varicella, and hepatitis B. The contract staff immunity documentation was put into files by 8/6/13. · Contract service pharmacy director A21 will complete all proper documentation of immunity to rubella, rubeola, and hepatitis B no later than 8/30/13, when he returns from being out of the office. 2. How are you going to prevent the deficiency from recurring in the future? · An audit of all dietary, EVS/housekeeping and pharmacy contracted staff health files has been completed to identify missing documentation. Contracted staff identified in this process must provide appropriate documentation or receive immunity titer by 8/30/13. · The protocol for dietary, EVS/housekeeping and pharmacy contracted staff pre-employment health screenings has been updated to include proper documentation of immunity to</b></p>				

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	<p>immunity to Varicella in the health file</p> <p>c. staff member #43, a food service worker, lacked documentation of immunity to Rubeola</p> <p>3. at 2:45 PM on 7/10/13, review of EVS/housekeeping health files indicated:</p> <p>a. staff member #44 had a form titled "Hepatitis B Vaccine Record" indicating the employee had received training at the time of hire related to the exposure control plan, but lacked marking whether they previously received the Hepatitis B series, requested the series, or declined receiving the Hepatitis B series</p> <p>b. staff member #45 lacked documentation in the health file of immunity to Rubella, Rubeola, or Varicella</p> <p>4. interview with staff member #68, the employee health nurse, at 2:00 PM on 7/10/13 indicated:</p> <p>a. the employee health department has no further immunization information for contracted dietary staff members #40, #42, and #43</p> <p>5. interview with staff member #52, the quality director, at 3:30 PM on 7/10/13 indicated:</p> <p>a. per the employee health department,</p>		<p><b>Rubella, Measles, Mumps, and Varicella, and Hepatitis B. A checklist has been developed for each employee file to ensure proper documentation is obtained on each new employee prior to being allowed to work. · The process of updating the protocol has been improved to meet same requirements and standards as any MGH employee as determined by the infection control committee, MGH Employee Health and MGH Work Solutions. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? · Director of Food and Nutrition Department · EVS Director · Pharmacy Director 4. By what date are you going to have deficiency corrected? 8/30/13</b></p>				

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	<p>they have no immunization documentation for the contracted housekeeper, staff member #45</p> <p>6. The personnel file for the contracted service pharmacy director staff A21 lacked documentation of immunity to rubella, rubeola, and hepatitis B.</p> <p>7. The personnel files for the contracted service housekeeping director staff A22 and housekeeping supervisor staff A23 lacked documentation of immunity to rubella, rubeola, varicella and hepatitis B.</p> <p>8. On 7-10-13 at 1400 hours, staff A5 indicated that no additional documentation regarding immunization status was available for the indicated staff.</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 policy and procedure review, observation, document review, and interview, the nursing staff failed to implement the policy related to the cleaning of refrigerators in 5 areas</p>	S000912	<p>S 912: 1-10 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p>	09/04/2013			

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	<p>toured (Emergency Department, 3 West Telemetry Unit, Critical Care Department, Acute Rehab Unit, and the Pediatric Unit).</p> <p>Findings:</p> <p>1. at 10:30 AM on 7/10/13, review of the policy and procedure "Maintenance of Pantries (cleaning, storage of food, rotation of supplies, closure of, temperature checks, etc.)", policy number NUR-053, with a last revised date of 10/20/2012 indicated:</p> <p>a. under "Policy", it reads: "It is the policy of Marion General Hospital to provide an environment for the storage of patient nourishments, a clean environment for preparing and serving of patient nourishments, and a schedule for routine cleaning and guidelines for the replacement of faulty equipment..."</p> <p>b. under "Responsibilities", it reads: "...10. Nursing is responsible for cleaning the pantries, including the refrigerator, freezer and counters..."</p> <p>c. under "Procedure", it reads: "...C. Refrigerator Cleaning and Inspections" (does not address how often the inside of the refrigerator will be cleaned, by whom, or with what product)</p> <p>2. while on tour of the ED (emergency department) in the company of staff member #55, the ED director, it was</p>		<ul style="list-style-type: none"> <li>· <b>All refrigerators identified in S912 lines, 2, 3, 4, 5, 6, 7, 8, 9, and 10 were thoroughly cleaned immediately after being identified by surveyors. In addition, staff in the ED, 3 West Telemetry, CCD, ARU, and Pediatrics was educated over the following several weeks during staff meetings or huddles, on the importance of thorough and timely cleaning of the refrigerators.</b></li> <li>2. How are you going to prevent the deficiency from recurring in the future? <ul style="list-style-type: none"> <li>· Nursing Policy NUR-053 Maintenance of Pantries (cleaning, storage or food, rotation of supplies, closure of, temperature checks, etc.) is being changed and updated as Environment of Care policy (EOC-907). EOC-907 will be submitted to Environment of Care Committee for approval at the next scheduled meeting September 4, 2013.</li> <li>· Standardized Refrigerator Cleaning Checklists will be used to document weekly cleaning. The completed Refrigerator Cleaning Checklists will be sent to Plant Engineering.</li> <li>· Refrigerator cleanliness monitoring will be incorporated into Environment of Care rounds.</li> </ul> </li> </ul>				

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	<p>observed on 7/8/13 at 11:50 AM in the pantry, that the patient refrigerator was dirty</p> <p>3. interview with staff member #55 at 11:50 AM on 7/8/13 indicated there is no schedule for routine cleaning of the pantry refrigerator and it was unknown the last time the refrigerator had been cleaned</p> <p>4. at 4:00 PM on 7/9/13, while on tour of the 3 West Telemetry unit, in the company of staff member #65, the Telemetry unit manager, it was observed that the pantry refrigerator was dirty under the two vegetable drawers with a large amount of dried, brown substance present</p> <p>5. at 4:10 PM on 7/9/13, one of the Telemetry nurses provided a "chore list" that indicated the refrigerator had been cleaned on 7/6/13</p> <p>6. at 4:35 PM on 7/9/13, while on tour of the CCD (critical care department) in the company of staff member #66, the CCD manager, it was observed in the pantry that the patient refrigerator was dirty under the two vegetable drawers and the grill at the bottom of the refrigerator</p>		<p>3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)?  Administrative Director of Plant Operations and Safety Officer.</p> <p>4. By what date are you going to have the deficiency corrected?  September 4, 2013</p>				

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	<p>7. at 9:50 AM on 7/10/13, while on tour of the ARU (acute rehab unit) in the company of staff member #63, the rehab manager, it was observed that the patient refrigerator, located in the gym area, was dirty under the vegetable drawers and the grill at the bottom of the refrigerator</p> <p>8. the "Weekly Cleaning List", provided by ARU staff at 9:55 AM on 7/10/13, indicated the refrigerator was last cleaned on 7/8/13 (and prior to that, on 6/25/13)</p> <p>9. at 10:20 AM on 7/10/13, while on tour of the Pediatric nursing unit in the company of staff member #62, the pediatric nurse manager, it was observed in the patient refrigerator that the lowest glass shelf had dirt/grime/dried liquids wedged between the shelf and the plastic edges it sat on. (just above the vegetable drawers)</p> <p>10. review of the staff provided "Pediatric Refrigerator Cleaning Log...Ensure refrigerator is clean" indicated the checking for cleanliness was initialed off for days 1 to 10 on the July calendar as having been checked for cleanliness by staff</p>						

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S000954	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(e)</p> <p>(e) Emergency equipment and emergency drugs shall be available for use on all nursing units. Based on document review, observation and interview, the facility failed to periodically inspect and maintain its automated external defibrillators (AED) and assure its emergency equipment was available for use at 1off-site.</p> <p>Findings:</p> <p>1. The Medtronics LifePak CR Plus AED Defibrillator Operating Instructions (2009) indicated the following: "...[the AED] performs an automatic self-test once a week ...If the automatic self-test detects a condition that requires attention, the Ok symbol in the readiness display will fade and either the CHARGE PAK symbol, the ATTENTION symbol, or the WRENCH symbol will appear ...On a regular basis, you should do the following: Check to make sure that the OK symbol is visible in the readiness display ...Check the Use By date on the electrode packet ...[and] ...Check other emergency supplies that may be stored with your defibrillator ...if the defibrillator is used only rarely, monthly inspections may be appropriate</p>	S000954	<p><b>S 954: 1 Informationals 954: 21. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · An Environment of Care policy (EOC-908) AED Defibulator Testing Policy has been developed, which includes a monthly inspection of each unit by Security Officers. The monthly inspections will be documented on an AED Checklist located next to each AED. · EOC-908 will be submitted for approval to the Environment of Care Committee during a regularly scheduled meeting on September 4, 2013. · The Medtronics LifePak CR Plus AED will continue to have preventative maintenance performed semi-annually by Clinical Engineering based on its defined risk assessment. 2. How are you going to prevent the deficiency from recurring in the future? · AED Checklists will be monitored during Environment of Care rounds and reported to the Environment of Care</b></p>	09/04/2013			

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	<p>... "</p> <p>2. The policy/procedure Crash Carts and Defibrillators, checking of (revised 9-10) failed to indicate a frequency for inspecting the AED and emergency equipment for operational readiness by a responsible person.</p> <p>3. On 7-09-13 at 1740 hours, during a tour of the South Marion outpatient radiology department, in an exam room containing ultrasound equipment, the following condition was observed: a Medtronics LifePack CR Plus AED (reinspect 11-28-13) was observed with two expired Portex First Response ambu-bags (adult ambu expired 5-09) (pediatric ambu expired 3-08).</p> <p>4. On 7-09-13 at 1740 hours, staff A6 confirmed that no periodic inspections were being performed by department staff or a responsible person and confirmed that the emergency equipment was expired.</p>		<p><b>Committee quarterly, as a required agenda item. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)?</b></p> <ul style="list-style-type: none"> <li>· Administrative Director of Plant Operations and Safety Officer</li> </ul> <p><b>4. By what date are you going to have the deficiency corrected?</b></p> <p><b>September 4, 2013 S 954: 3 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The outdated Portex First Response ambu-bags were replaced on 7/11/13. 2. How are you going to prevent the deficiency from recurring in the future? The bags will be checked monthly by the Radiology department supervisors and replaced before expiration. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)?</b></p> <ul style="list-style-type: none"> <li>Radiology Managers</li> </ul> <p><b>4. By what date are you going to have the deficiency corrected?</b></p> <p><b>7/11/13 S 954: 4 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · The Medtronics LifePack CR Plus AED was tested on 7/11/13. · The outdated Portex First</b></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><b>Response ambu-bags were replaced on 7/11/13. 2. How are you going to prevent the deficiency from recurring in the future? · The Medtronics LifePack CR Plus AED will be inspected monthly by a properly trained Security Officer, monitored during Environment of Care rounds, and reported to the Environment of Care Committee quarterly. · The bags will be checked monthly by the Radiology department supervisors and replaced before expiration. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? · Administrative Director of Plant Operations and Safety Officer · Radiology Managers 4. By what date are you going to have the deficiency corrected? 7/11/13</b></p>		

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	<p>Based on policy and procedure review, observation, and staff interview, the facility failed to ensure that no condition occurred that might create a hazard, or ill effect, for patients, staff, or visitors in 8 areas toured (Emergency Department, Critical Care Department, Post Anesthesia Care Unit, Out Patient Surgery; 3 Central and 3 West Telemetry, Acute Rehab Unit and Morgue).</p> <p>Findings:</p> <p>1. at 1:00 PM on 7/10/13, review of the policy and procedure "Plan for the Provision of Care/Service", with no policy number and a last reviewed date of 09/12, indicated:</p> <p>a. on page two under "Departmental Inventories", it reads: "[the facility] utilizes a Par Cart system to maintain adequate levels of supplies on the patient care units and support departments...staff rotates stock to insure supplies used are within the expiration dates and discard outdated supplies from patient care areas..."</p> <p>2. at 11:45 AM on 7/8/13, while on tour of the ED (emergency department) in the company of staff member #55, the ED manager, it was observed in the casting room cupboards a sterile Portex brand infant lumbar puncture kit that was</p>	S001118	<p><b>S 1118: 1</b> Informational <b>S 1118: 2 &amp; 31. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. On 7/8/13, the Lumbar Puncture Tray was immediately removed from the room and properly disposed.</b></p> <p><b>2. How are you going to prevent the deficiency from recurring in the future? 1. Education given to all staff in the 7/29/13 – 8/4/13 weekly huddles outlining the following steps: a. Any sterile item fully or partially opened and not used must be properly disposed of immediately. b. When stocking rooms daily, any sterile item found to have seal broke must be properly disposed of upon discovery.</b></p> <p><b>3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? Administrative Director of ED, EMS and AI</b></p> <p><b>4. By what date are you going to have the deficiency corrected? 08/04/13</b></p> <p><b>S 1118: 4 &amp; 51. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The expired lavender tube was immediately disposed of by the CCD nurse on July 9, 2013. All other lab</b></p>	09/04/2013			

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	<p>opened and no longer sterile</p> <p>3. interview with staff member #55 at 11:45 AM on 7/8/13 indicated the opened kit should have been removed by staff and not left in the cupboard</p> <p>4. at 4:40 PM on 7/9/13, while on tour of the CCD (critical care department) in the company of staff member #66, the CCD manager, it was observed in the medication room, in a top drawer, one lavender top lab tube that expired 11/12</p> <p>5. interview with staff member #66 at 4:40 PM on 7/9/13 indicated the lab tubes are to be kept in the bottom drawer and it is unknown why this expired tube was in the top drawer</p> <p>6. at 9:30 AM on 7/9/13, while on tour of the PACU (post anesthesia care unit) in the company of staff member #58, the surgery manager, it was observed in the storage room that 8 Arrow brand peritoneal lavage kits had expired 8/12</p> <p>7. interview with staff member #58 at 9:35 AM on 7/9/13 indicated: a. it was thought that these kits had been brought from the outpatient surgery center b. staff should have noted the expiration dates prior to this observation</p>		<p><b>tubes in the CCD were double checked for past-due expiration dates, and no other expired dates were found on the remaining lab tubes on July 9, 2013. 2. How are you going to prevent the deficiency from recurring in the future? Staff education was done on July 9, 2013 regarding lab tube storage. CCD staff was educated that all lab tubes were to be stored in the bottom drawer so routine expiration dates could be checked on lab tubes. On July 9, 2013, checking lab tube expiration dates was added to the nurse's chore list to be done monthly. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? Administrative Director of CCD 4. By what date are you going to have the deficiency corrected? July 9, 2013 S 1118: 6 &amp; 71. How are you going to correct the deficiency? If already corrected include the steps taken and the date of the correction: a. The 8 Arrow brand peritoneal lavage kit is no longer being used by the Hospital. All 8 Arrow brand peritoneal lavage kits were discarded on 7/10/13. 2. How are you going to prevent the deficiency from recurring in the future? a. Staff was educated</b></p>		

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	<p>and removed them as they are no longer utilized at the facility</p> <p>8. at 10:20 AM on 7/9/13, while on tour of the PACU in the Out Patient Surgery area, in the company of staff member #58, the surgery manager, it was observed that there was dust under the lowest shelf of the Amsco blanket warmer</p> <p>9. interview with staff member #58 at 10:20 AM on 7/9/13 indicated there is no routine cleaning of the blanket warmer to remove the dust that accumulates</p> <p>10. at 3:40 PM on 7/9/13, while on tour of the 3 Central Telemetry nursing unit in the company of staff member #65, the telemetry manager, it was observed that the glucometer control solution #1 lacked a date of either when opened, or when it will expire--the date was smudged off and unreadable</p> <p>11. at 4:00 PM on 7/9/13, while on tour of the 3 West Telemetry nursing unit in the company of staff member #65, the telemetry manager, it was observed in the pantry that an ice scoop was located in a plastic bag on the wall beside the floor model ice machine</p>		<p><b>to watch for expired product during the morning huddle on 07/11/13. b. Supply Coordinators will continue to rotate products routinely and check for outdates while putting supplies away. c. Products are checked at the annual physical inventory for outdates. 3. Who is going to be responsible for items 1&amp;2 above (e.g. director, supervisor, etc.)? a. The Supply Coordinators, all staff and supervisors will be responsible for checking outdates and rotating stock. 4. By what date are you going to have the deficiency correct? 07/10/13S 1118: 8 &amp; 91. How are you going to correct the deficiency? If already corrected include the steps taken and the date of the correction: a. All blanket warmers with lower shelves were cleaned on 7/10/13. 2. How are you going to prevent the deficiency from recurring in the future? a. A column was added to the blanket warmer log to clean the blanket warmer. b. The blanket warmer logs will be monitored by designated staff daily. c. All staff in the Surgical Services departments was educated on the new column on the blanket warmer log during the morning huddles and staff meetings by 7/24/13. d. A new policy for</b></p>				

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	<p>12. interview with staff member #65 at 3:40 PM and 4:00 PM on 7/9/13 indicated:</p> <p>a. it cannot be determined when the control solution, found on the 3 Center nursing station, expires since the date of opening, or expiration, is not readable</p> <p>b. staff are to use a permanent marker/pen when noting dates on the control solutions so they don't smudge</p> <p>c. it is unknown when the ice scoop might be cleaned, or if it is cleaned or sanitized, on a regular basis</p> <p>d. it is unknown how often the plastic bag the ice scoop is placed within, when not in use, is replaced</p> <p>13. at 10:00 AM on 7/10/13, while on tour of the ARU (acute rehab unit) in the company of staff members #63, the rehab manager, and #64, the rehab director, it was observed that a portable suction machine on the crash cart had no asset tag number, and no indication of preventive maintenance</p> <p>14. interview with staff member #67, biomedical staff member, at 10:45 AM on 7/10/13 indicated the portable suction had not been properly placed into service, had no asset tag number and had not had preventive maintenance performed prior to putting in it in place for use on the nursing unit</p>		<p><b>Blanket Warmer EOC-906 is being developed to include the following related to cleanliness:</b></p> <ul style="list-style-type: none"> <li>· All blanket/fluid warmers will be monitored daily and cleaned on a routine basis as documented on the blanket warmer log.</li> <li>· The blanket/fluid warmer unit will be inspected for cleanliness and wiped down with a clean cloth.</li> <li>e. The Blanket Warmer policy, EOC-906 will be presented at the already scheduled Environment of Care meeting on 9/4/13.</li> </ul> <p><b>3. Who is going to be responsible for items 1&amp;2 above (e.g. director, supervisor, etc.)?</b></p> <p>a. Administrative Director of Surgical Services b. Administrative Director of Plant Operations and Safety Officer</p> <p><b>4. By what date are you going to have the deficiency correct?</b> 07/10/13S 11:18: 10 &amp;12</p> <p><b>How are you going to correct the deficiency? If already corrected, include the steps taken and date of completion.</b></p> <p>Glucometer control solution found in the unit was thrown out and replaced by a new one. Staff was instructed/educated in our huddles; when opening a control solution for the glucometer, they are to place a piece of tape over the markings of the date and time so it does not rub off. <b>How are you going to prevent from recurring in the future?</b> The</p>				

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	<p>15. interview with staff member #52, the quality manager, at 1:00 PM on 7/10/13 indicated:</p> <p>a. the facility does not have a policy related to monitoring lab tubes on the units and their expiration dates</p> <p>b. there is no facility policy related to nursing staff responsibility of checking for expiration of supplies and products on their units</p> <p>c. staff are educated at the time of hire to rotate stock so as to use products with earlier expiration dates first and to check expiration dates with removal of expired items</p> <p>d. there is no facility policy related to blanket warmers, monitoring of temperatures, and routine cleaning to remove accumulated dust</p>		<p>glucometer solutions will be monitored daily by the PCA who does the Blood Sugars, and if the date is not clear the solution will be thrown out, a new one will be used, and the employee will be notified of the proper procedure.</p> <p><b>Who is going to be responsible for items 1 &amp; 2 above?</b> The Unit Shift Manager (Charge Nurse). <b>By what date are you going to have deficiency corrected?</b> 07/09/2013 <b>S 1118: 111.</b> How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The ice scoop in the bag on the wall in the Telemetry unit pantry was removed on July 9, 2013. 2. How are you going to prevent the deficiency from recurring in the future? · Two ice scoops and the correct holder were installed on August 5, 2013 for each ice machine. Every morning the secretary will place the clean ice scoop in the holder and send the 2 nd scoop to dietary to be sanitized. Dietary will then deliver the sanitized scoop back to the unit at lunch time. Clean scoops will come packaged from the kitchen ready to be placed the next morning. · Ice scoop cleaning log sheet will be kept in the Nourishment room. Completed log sheets will be maintained by the Administrative Director. 3. Who is going to be responsible for items 1 &amp; 2 above</p>		

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			(e.g. director, supervisor, etc.)? Administrative Director of Telemetry & Medical Surgical Units 4. By what date are you going to have the deficiency corrected? Complete on: August 5, 2013 <b>S 1118: 13-14</b> 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · On 7/10/2013, the portable suction machine on the crash cart was taken immediately out of service by Clinical Engineering. · Clinical Engineering tested the unit, placed an asset tag number on it, documented it in the hospital inventory, and returned the unit back to ARU. 2. How are you going to prevent the deficiency from recurring in the future? · All equipment purchases will go through the purchasing department, and go through Clinical Engineering prior to being put in services in accordance with <i>EOC-413 Incoming Inspection Policy</i> . 3. Who is going to be responsible for items 1 & 2 above (e.g. director, supervisor, etc.)? · Administrative Director of Plant Operations and Safety Officer 4. By what date are you going to have the deficiency corrected? · July 10, 2013 <b>S 1118: 15a-c1</b> . <b>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · Environment of Care policy EOC- 905, Rotation</b>		

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			<p><b>of Supplies has been developed outlining facility requirements for rotating stock and disposing of outdated product. EOC-905 will be submitted to the Environment of Care Committee for approval at the next scheduled meeting September 4, 2013. 2. How are you going to prevent the deficiency from recurring in the future? · Patient Care Staff will be retrained to rotate supplies when they are restocking in accordance with EOC-905. · Monitoring of expired product will be reviewed during Environment of Care rounds. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? · Administrative Director of Plant Operations and Safety Officer 4. By what date are you going to have the deficiency corrected? · September 4, 2013 S1118: 15 (d) 1. How are you going to correct the deficiency? If already corrected include the steps taken and the date of the correction: · Environment of Care policy Blanket and Fluid Warmer Policy (EOC-906) has been developed to include daily temperature monitoring and routine cleaning. · The Blanket and Fluid Warmer Policy (EOC-906) will be submitted for</b></p>	

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			<p><b>approval at the already scheduled Environment of Care meeting on September 4, 2013. 2. How are you going to prevent the deficiency from recurring in the future? · The Blanket Warmer Temperature/Cleaning log form will be used to document daily temperature control checks and weekly cleaning. · The completed Blanket Warmer Temperature/Cleaning log forms will be sent to Plant Engineering monthly. · Blanket Warmer monitoring will be incorporated into Environment of Care rounds. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.) Administrative Director of Plant Operations and Safety Officer 4. By what date are you going to have the deficiency correct? September 4, 2013 S 1118: 16 - 181. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · An ANSI approved eye wash station was ordered on 7/26/13 and will be installed upon delivery. Expected delivery date is 8/7/13. 2. How are you going to prevent the deficiency from recurring in the future? · During Environment of Care rounds, areas will be</b></p>		

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	<p>16. The Occupational Safety and Health Administration (OSHA) general requirements for emergency showers and eye wash station equipment in 29 Code of Federal Regulations (CFR) 1910.151(c) indicated the following: " When the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. "</p> <p>17. On 7-08-13 at 1520 hours, the following condition was observed in the morgue area: a closed 1 gallon container of Labsco Advantage 10% Formalin with a package warning label indicating the following: " Eye Contact: Immediately flush with plenty of water for at least 15 minutes " and no emergency eye wash equipment was</p>		<p><b>reviewed for caustic chemical use to identify if additional eye wash stations are necessary. ANSI approved eye wash stations will be installed as needed. 3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? · Administrative Director of Plant Operations and Safety Officer</b></p> <p><b>4. By what date are you going to have the deficiency corrected? · 8/9/13</b></p>		

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S001160	<p>present in the area if needed.</p> <p>18. During an interview on 7-08-13 at 1520 hours, staff A6 confirmed that no eyewash station was immediately available.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on observation and interview, the facility failed to regularly service and maintain its equipment in good working order for 2 housekeeping department floor buffers observed on tour.</p> <p>Findings:</p> <p>1. During a tour on 7-08-13 at 1605 hours, in the 2nd floor soiled utility/housekeeping closet, two Janitors Supply 175 rpm floor buffers were observed without evidence of recent preventive maintenance (PM) and one floor buffer was observed with a broken electrical grounding pin.</p> <p>2. During an interview on 7-08-13 at 1605 hours, staff A6 confirmed that the</p>	S001160	<p>S 1160: 1 &amp; 2</p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <ul style="list-style-type: none"> <li>· On July 11, 2013, the floor buffing units were taken immediately out of service by Plant Operations.</li> <li>· Plant Operations tested and/or fixed the unit and other similar devices, placed asset tag numbers on them, documented it in the hospital inventory, and returned units back to department.</li> </ul> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <ul style="list-style-type: none"> <li>· All equipment purchases will go through the purchasing department, and go through</li> </ul>	07/11/2013	

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S001172	<p>floor scrubbers lacked evidence of recent PM and had not been maintained.</p> <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 document review, observation, and staff interview, the EVS (environmental services) staff failed to ensure cleanliness/asepsis of the facility in 7 areas toured (Emergency</p>	S001172	<p>Clinical Engineering prior to being put in services in accordance with <i>EOC-413 Incoming Inspection Policy</i>.</p> <p>3. Who is going to be responsible for items 1 &amp; 2 above (e.g. director, supervisor, etc.)? · Administrative Director of Plant Operations and Safety Officer</p> <p>4. By what date are you going to have the deficiency corrected? July 11, 2013</p> <p><b>S 1172: 1 InformationalS 1172: 21.</b> How are you going to correct the Deficiency? If already corrected, include the steps taken and the date corrected. All areas identified in the medication room</p>	08/28/2013			

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	<p>Department, Post Anesthesia Care Unit, Surgery Department, Acute Rehab Unit, the Pediatrics Unit, dining room and biohazard waste storage).</p> <p>Findings:</p> <p>1. at 2:45 PM on 7/10/13, review of the "10 Step Cleaning Process Checklist" used for orienting housekeeping staff to the process of cleaning, indicated the staff member is to: "Interact with patient; Empty Waste Receptacles; High Dust; Sanitize; Spot Clean; Restroom; Dust Mop; Inspect; Damp Mop; Interact with the Patient"</p> <p>2. at 12:05 PM on 7/8/13, while on tour of the ED (emergency department) in the company of staff member #55, the ED manager, it was observed in the medication room (with pyxis machines) that:</p> <p>a. the window ledge was dirty</p> <p>b. the narrow blinds were covered with dust and had splashes of a brown liquid on them</p> <p>c. there were strings/fingerlings of dust hanging down 4 to 6 inches from the top of the window frame between the blinds and the window</p> <p>d. there was dust, dirt, and papers on the floor between the two pyxis machines</p> <p>e. there was accumulated dirt around</p>		<p>in the Emergency Department (a-e) were cleaned on July 10, 2013. 2. How are you going to prevent the deficiency from recurring in the future? Medication room cleaning in the ED has been assigned to the day shift employee where it can be monitored by EVS management. Formal monthly rounding with nursing unit managers and EVS manager will continue, including documented observation of EVS employees. Five observation QA's will be accomplished each week by EVS supervision. The results of those QA's will be submitted to the EOC (environment of care) committee and to the quality department. 3. Who is going to be responsible for items 1 &amp; 2 above? EVS Director 4. By what date are you going to have deficiency corrected? July 10, 2013<b>S 1172: 3 &amp; 41.</b> How are you going to correct the deficiency? If already corrected, include the steps taken and the date corrected. All areas identified in the Medical/Surgical Nursing Unit listed in Finding 3 (a-b) were cleaned on July 11, 2013. The area identified in the PACU (Post anesthesia care unit) listed in Finding 4 was cleaned on July 12, 2013. 2. How are you going to prevent the deficiency from recurring in the future? Rolling stock on the nursing units such as WOW's (workstation on wheels), carts, and chair legs will be cleaned by</p>		

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	<p>the floor edges of the room, especially under the window</p> <p>3. at 2:10 PM on 7/8/13, while on tour of the medical/surgical nursing unit in the company of staff member #54, the evening charge nurse, it was observed that:</p> <p>a. the bottom shelf of the Artromick brand BMV (bedside medication verification) cart was covered with dust/dirt</p> <p>b. two office chairs in the hallway were dusty on the bases</p> <p>4. at 9:35 AM on 7/9/13, while on tour of the PACU (post anesthesia care unit), in the company of staff member #58, the surgery manager, it was observed that the "block" cart was dusty on the bottom edges</p> <p>5. at 10:15 AM on 7/9/13, while on tour of the surgery department in the company of staff member #58, the surgery manager, it was observed that the tops of the lockers in the women's changing room were covered with a large layer of dust</p> <p>6. at 10:00 AM on 7/10/13, while on tour of the ARU (acute rehab unit) in the company of staff member #63, the ARU manager, it was observed</p>		<p>EVS staff. Formal monthly rounding with nursing unit managers and EVS manager is will continue, including documented observation of EVS employees. Five observation QA's will be accomplished each week by EVS supervision. The results of those QA's will be submitted to the EOC (environment of care) committee and to the quality department. 3. Who is going to be responsible for items 1 &amp; 2 above? EVS Director 4. By what date are you going to have deficiency corrected? July 12, 2013<b>S1172: 51.</b> How are you going to correct the deficiency? If already corrected, include the steps taken and the date corrected. The area identified in the women's changing room of the Surgery Department listed in Finding 5 was cleaned on July 10, 2013. 2. How are you going to prevent the deficiency from recurring in the future? Formal monthly rounding with nursing unit managers and EVS manager is will continue, including documented observation of EVS employees. Five observation QA's will be accomplished each week by EVS supervision. The results of those QA's will be submitted to the EOC (environment of care) committee and to the quality department. 3. Who is going to be responsible for items 1 &amp; 2 above? EVS Director 4. By what date are you going to have deficiency</p>				

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	<p>that:</p> <p>a. there was a layer of dust on the top of the plastic canister of the portable suction machine on the crash cart</p> <p>b. the bottom edges and wheel covers of the crash cart were dirty/dusty</p> <p>7. at 10:10 AM and 10:35 AM on 7/10/13, while on tour of the Pediatric nursing unit in the company of staff member #62, the obstetric and pediatric nurse manager, it was observed that:</p> <p>a. the bottom shelf of the WOW (workstation on wheels) cart was dusty/dirty</p> <p>b. the bottom of the yellow isolation cart was very dusty</p> <p>8. interview with the EVS supervisor/manager, staff member #56, at 10:50 AM on 7/9/13 indicated:</p> <p>a. there is no documented observation of housekeeping staff performing their duties</p> <p>b. EVS staff check off a self attestation of cleaning duties performed on their shifts</p> <p>9. interview with staff member #61, the infection preventionist, at 2:00 PM on 7/9/13 indicated:</p> <p>a. there is currently no environmental rounding done by the infection preventionist to observe for cleanliness</p>		<p>corrected? July 10, 2013 <b>S1172: 6-71</b>. How are you going to correct the deficiency? If already corrected, include the steps taken and the date corrected. All areas identified in the ARU (acute rehab unit) listed in Finding 6 (a-b) were cleaned on July 11, 2013. All areas identified in the Pediatric nursing unit listed in Finding 7 (a-b) were cleaned on July 11, 2013. 2. How are you going to prevent the deficiency from recurring in the future? Rolling stock on the nursing units such as WOW's (workstation on wheels), carts, and chair legs will be cleaned by EVS staff. Formal monthly rounding with nursing unit managers and EVS manager is will continue, including documented observation of EVS employees. Five observation QA's will be accomplished each week by EVS supervision. The results of those QA's will be submitted to the EOC (environment of care) committee and to the quality department. 3. Who is going to be responsible for items 1 &amp; 2 above? EVS Director 4. By what date are you going to have deficiency corrected? July 11, 2013 <b>S 1172: 8-11</b> 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date corrected. · EVS staff is currently monitored while performing their duties. To document these observations, the staff self-attestation check list</p>				

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	of the facility b. observation of housekeeping staff in the performance of their duties has not been accomplished by this staff person to date		was updated on August 1, 2013 to include a section for an EVS supervisor to document that they have reviewed the employee's progress during the day. · EOC (environment of care) rounding currently is accomplished and will continue with unit manager, infection control coordinator, POM (plant operation and maintenance) manager, BioMed manager and EVS manager. The standardized check list used in the EOC rounds was updated on July 10, 2013 to include observation of EVS employees performing his/her duties. · In addition to the above scheduled EOC (environment of care) rounding, random quarterly EOC rounds of critical areas for compliance with cleaning policies and procedures will occur. Areas of specific attention are to include the surgical suites. Both the main and ambulatory suites will have at least one unannounced observation rounding each quarter. · Contracted housekeeping service policies and procedures will be reviewed and approved at the already scheduled infection control committee meeting on August 28, 2013. 2. How are you going to prevent the deficiency from recurring in the future? Formal monthly rounding with nursing unit manager, infection control coordinator, POM manager, BioMed Manager, and EVS manager will continue, including		

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NAME OF PROVIDER OR SUPPLIER  MARION GENERAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 441 N WABASH AVE MARION, IN 46952
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			<p>documented observation of EVS employees. Five observation QA's will be accomplished each week by EVS supervision. The results of those QA's will be submitted to the EOC (environment of care) committee and to the quality department. 3. Who is going to be responsible for items 1 &amp; 2 above? EVS Director EOC team to include the Infection Control Coordinator 4. By what date are you going to have deficiency corrected? August 28, 2013</p> <p><b>S 1172: 12-13</b></p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date corrected.</p> <p>Dust has been removed from all areas of the first and second floor structural elements with the use of a lift. Lobby completed July 26, 2013. Café window ledges completed July 31, 2013. Ceiling decorative features completed August 2, 2013.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <p>Regular rounding of these areas will be documented by EVS manager.</p> <p>3. Who is going to be responsible for items 1 &amp; 2 above?</p> <p>EVS Director</p>	

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	10. On 7-10-13 at 0930 hours, staff A5 was requested to provide documentation indicating that the contracted housekeeping service policies and procedures were approved by the		<p>4. By what date are you going to have deficiency corrected?</p> <p>August 2, 2013 <b>S 1172: 14-15</b></p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date corrected.</p> <p>The biohazard waste storage room floor was scrubbed and cleaned on July 9, 2013.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <p>The biohazard waste storage room will be swept and mopped at the end of each shift. On August 1, 2013, a log was placed into effect including a place for the trash tech to sign off on their cleaning.</p> <p>3. Who is going to be responsible for items 1 &amp; 2 above?</p> <p>EVS Director</p> <p>4. By what date are you going to have deficiency corrected?</p> <p>July 9, 2013</p>		

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	<p>hospital infection control committee and none was provided prior to exit.</p> <p>11. The EVS documentation titled 10 Step Cleaning Process Checklist (used for validating EVS staff orientation to the process of cleaning) indicated the following: "Interact with Patient; Empty Waste Receptacles; High Dust; Sanitize; Spot Clean; Restroom; Dust Mop; Inspect; Damp Mop; Interact with the Patient ..."</p> <p>12. During a tour on 7-08-13 at 1510 hours, the following conditions were observed in the main dining room of the facility: a significant accumulation of dust and particulate material was present on the structural elements and decorative finish of the ceiling areas and second story window sills were observed to have accumulated dust on the horizontal surfaces.</p> <p>13. On 7-08-13 at 1510 hours, staff A6 confirmed the dining room ceiling and window sills had not been kept clean.</p> <p>14. During a tour on 7-08-13 at 1535 hours, the following condition was observed in the biohazard waste storage room: a 1 " wide by 1 " tall accumulation of dirt and debris was present around the room perimeter at the junction of floor and wall surfaces.</p>				

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	15. On 7-08-13 at 1535 hours, staff A6 confirmed the biohazard waste storage room had not been kept clean.			