

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2014
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005023</p> <p>Survey Date: 6-9/12-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Linda Dubak, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 06/24/14</p>	S000000		
S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but</p>			

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

TITLE

(X6) DATE

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

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	<p>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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation, interview and document review, the hospital failed to implement their policies on personal hygiene and surgical attire in one of one burn unit operating room, and one of one patient care areas.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 6/10/14 at 12:20 pm, it was observed in the burn unit operating room, marked as a restricted area, three female care providers with earrings visible, not covered by surgical hats during an open debridement case. 2. At 12:25 pm, interview with the floor manager, M#2 confirmed the three care providers with exposed earrings and indicated the burn unit operating room followed the hospital policy for surgical attire. 3. Hospital policy, Surgical Attire, 660-21, page 3, D. "All personnel entering the restricted area of the surgical 	S000608	<p>Nursing leadership was informed of the finding during the ISDH visit during a Blue Team meeting on June 18, 2014. The Director of the Burn Unit added re-education of "Surgical Attire 660-21" to the staff meeting agendas for July 2014. The assessment of clinical staff wearing jewelry during when involved in cases requiring sterile attire will be added to Patient Safety Rounds and will be assessed by the infection control members of the Patient Safety Round Team. Clinical leaders of departments that perform sterile procedures will routinely assess staff members for jewelry worn during cases and will re-educate as necessary. The information was further discussed during Quality Council on July 1, 2014. The policy was reviewed and staff members present were educated regarding the infection control concerns related to not being compliant with Policy 660-21. The Manager of Infection Prevention and Control will be responsible for ensuring compliance with this policy. The Chief Medical Officer</p>	07/31/2014

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	<p>suite should confine or remove all jewelry. b. Other jewelry (e.g. watches, earrings, bracelets, necklaces, piercings) may be worn but will be removed or totally confined within the scrub attire as required for patient care. Jewelry that cannot be confined within the surgical attire would be removed before entry into the semi restricted and restricted area."</p> <p>4. On 6/11/14 at 8:45 am, at Cottage Corners Clinic, it was noted a physician, D#1 opened the door of an exam room with gloves still on and walked out of the room carrying a pen and the chart. The physician proceeded to the nurse station and then removed the gloves and washed his hands. It was noted the exam room contained a handwashing sink and a trash container and hand sanitizer was available on the wall.</p> <p>5. Interview with the clinic manager, M#3 confirmed physician, D#1 had walked out of the exam room with gloves still on and indicated D#1 had been counseled before for this.</p> <p>6. Hospital policy, Hand Hygiene, 910-144, page 2, 4, Gloves, "Wash hands before donning gloves, remove gloves after caring for a patient. Personnel should not wear the same pair of gloves for the care of more than one patient.</p>		<p>for the Eskenazi Medical Group was notified of the finding related to the physician at Cottage Corner and poor hand hygiene on June 11,2014. The physician was counseled by the Chief Medical Officer the following day. The site manager of Cottage Corner will be responsible for monitoring the physician's compliance with hand hygiene. The Eskenazi Medical Group CMO will be responsible for communicating further issues of non-compliance with this specific physician. Overall,throughout the system, Hand Hygiene audits are routinely conducted in all areas, on all shifts, and for all disciplines. These audits will continue with necessary follow up completed.</p>				

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S000952	<p>Perform hand hygiene immediately after removal of gloves."</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to implement approved medical staff polices/procedures for the administration of 1 of 7 transfusions administered.</p> <p>Finding include: 1. On 6/9/14 a transfusion administration policy/procedure titled: "Obtaining/Administering Blood and Blood Components, 600-004, Effective Date: 2/1/84, Revised date: 1/1/13" was reviewed and it stated: "7C. Vital signs must be completed and documented:" a. " i Pre-transfusion (baseline)" b. "ii 15 minutes after transfusion is begun." c. "iii At the end of the transfusion."</p>	S000952	<p>Transfusion audits occur at Eskenazi Health on a bi-weekly basis. Units of blood are followed to the units and each step of the policy is audited for proper timing and documentation as well as for compliance with the transfusion consent policy. The findings from these audits demonstrate a compliance rate of over 90% for the past 6months with the accurate completeness of the transfusion documentation form. The information related to this finding of noncompliance was discussed with clinical leadership during the Blue Team meeting on June 18, 2014. The deficiency was also discussed at Quality Council on July 1, 2014. Both groups felt the RN being a member of the Per Diem nursing pool was a contributing factor to this finding. A message was</p>	07/31/2014

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S001020	<p>2. On 6/10/14 from 1: 15 p.m. to 3:00 p.m. review of 6 rbc (red blood cell) normal transfusions and one called reaction rbc transfusion indicated transfusion T#4 was not performed per policy/procedure because the 15 minute time was the same as the start time.</p> <p>3. SP#1 (SP=Staff Person) confirmed in interview on 6/10/14 between 3:00 p.m. and 3:30 p.m. the incorrect time was on the transfusion record.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on document review and</p>	S001020	<p>drafted to be forwarded to all members of the Per Diem nursing pool to refer them to internal unit and education resources in the event they have questions with the appropriate timing and subsequent documentation related to blood transfusions. An RN from the Quality and Risk Management team will be responsible for the ongoing audits associated with transfusions. The data will continue to be presented at monthly Quality Council meetings. Specific units or staff members demonstrating non-compliance will receive targeted education. Further, the organization will have a module on blood transfusions and associated documentation during mandatory Annual Clinical Education to be held during the 3rd and 4th quarter of 2014.</p> <p>The following off site locations will</p>	07/31/2014

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	<p>interview, the hospital failed to ensure the monthly inspection of 11 areas where drugs are stored.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a document entitled Medication Area Inspections, 731-544, revised 10/1/2011, indicated a licensed pharmacist or designee will complete monthly inspections of the pharmacy and each nursing unit or area of the hospital or clinics that maintain supplies of pharmaceuticals. In interview, on 6-12-14 at 10:00 am, employee #A9 indicated there were not monthly reports done for offsites, only every other month for the following 11 offsites: Eskenazi Health Center - North Arlington Eskenazi Health Center - Pecar Eskenazi Health Center - Westside Eskenazi Health Center - West 38th Street Eskenazi Health Center - Blackburn Eskenazi Health Center - Linwood Eskenazi Health Center - Cottage Corner Eskenazi Health Center - Eagledale Eskenazi Health Center - Forest Manor Eskenazi Health Center - Grassy Creek Narcotics Treatment Program 		<p>have monthly pharmacy inspections with accompanying reports starting during July 2014: Eskenazi Health Center- North Arlington Eskenazi Health Center-Pecar Eskenazi Health Center-Westside Eskenazi Health Center-West 38th Street Eskenazi Health Center-Blackburn Eskenazi Health Center-Linwood Eskenazi Health Center-Cottage Corner Eskenazi Health Center-Eagledale Eskenazi Health Center-Forest Manor Eskenazi Health Center-Grassy Creek Midtown's Narcotics Treatment Program The QA/QI Pharmacist will be responsible for ensuring monthly inspections of each of these locations. Any site with noncompliance will be reported to the Director of Pharmacy. The change in process from performing rounds every other month to every month will allow for compliance with Policy 731-544, Medication Area Inspections.</p>	

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 1 instance.</p> <p>Findings:</p> <p>1. On 6-9-14 at 12:25 pm in the presence of employees #A2 and #A4, it was observed in Room H1B22, the pulmonary function area, there was a large compressed gas cylinder tank standing upright on the floor inadequately secured by chain or holder.</p> <p>2. If the above tank was knocked over and broke the head off the compressed cylinder, it could result in harm to people</p>	S001118	Work order 5795 was issued on July 3, 2014 to the Facilities Engineering Department to secure all compressed gas cylinders in the Pulmonary Function Lab. The Environmental Safety Officer will be responsible for ensuring this work order gets completed and for routine assessment of the lab to promote ongoing compliance with compressed gas safety.	07/16/2014			

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S001164	<p>and/or property.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on observation, document review and interview, the facility failed to ensure evidence of preventive maintenance (PM) on 2 pieces of equioment.</p> <p>Findings:</p> <p>1. On 6/10/14 at 9:20 am, it was observed in the trauma operating suite in OR, a Stryker EHD Electrical Saw, had a PM sticker with the number 100890. This sticker indicated the equipment was last checked by BioMed on 1/13/12 and was due to be next checked by 1/13/13.</p> <p>2. In interview, a check with BioMed indicated the equipment had not been</p>	S001164	Formal Patient Safety Rounds take place in clinical areas twice per year. During these rounds a specific focus is placed on equipment in need of preventive maintenance. The leaders of clinical areas also look for overdue equipment when rounding in their areas. The electrical saw was missed during these assessments. The Bio Med team located the saw in the OR and the PM was completed on June 11, 2014. Members of the Environmental Services leadership team met on June 16th, 2014 with the Environmental Safety Officer to develop a process and a document to track compliance with the process of preventive maintenance and periodic assessment. The new process	07/31/2014

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S001168	<p>checked since 1/13/12.</p> <p>3. On 6-9-14 at 11:00 am, employee #A2 was requested to provide documentation of PM on a floor scrubber.</p> <p>4. In interview, on 6-11-14 at 9:40 am, employee #A8 indicated there was none and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the hospital failed to follow the manufacturer's recommendation for testing, each shift, 1 of 1 defibrillator and failed to follow the manufacturer's recommendation of types of checks and testing to be conducted for 2 of 2 defibrillators.</p> <p>Findings:</p>	S001168	<p>involves a daily check with an accompanying checklist and annual preventive maintenance. The floor scrubber will receive preventive maintenance prior to the end of July 2014. The Director of EVS is responsible for meeting this deadline and for monitoring of ongoing compliance.</p> <p>Policy950-126, CPR/Code Blue Response will undergo revision to be more specific in demonstrating compliance with the manufacturer's recommendations. The current process of Eskenazi clinical areas with defibs and emergency equipment is to assess the defib and the equipment daily according to an organizational checklist. The checklist requires a daily firing of the defib. The</p>	07/31/2014

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	<p>1. Review of the manufacturer's recommendation for the Heart Start XL+ defibrillator indicated to test it once each shift.</p> <p>2. Review of a hospital policy entitled Cardiopulmonary Resuscitation/Code 99 Response, 950-126, indicated the emergency equipment will be checked every 24 hours the area is in operation.</p> <p>3. Review of a document entitled Emergency Equipment Checklist, for June, 2014, Unit 8W, Defibrillator #: 115049, indicated the defibrillator was checked and tested once each day.</p> <p>4. Review of the manufacturer's recommendation for the Heart Start XL+ defibrillator indicated there were various specific shift checks and tests to be done.</p> <p>5. Review of a hospital policy entitled Cardiopulmonary Resuscitation/Code 99 Response, 950-126, did not indicate which manufacturer's recommended various specific shift checks and tests were to be done. Further review of the document did not indicate reference to the manufacturer's recommendations for the various specific checks to be done each shift.</p>		<p>manufacturer, Philips, maintains their version of a checklist should be followed each shift and the defib should only be fired once per week. Historically, our stance has been we feel more comfortable firing the defib daily to monitor functionality. The Philips defibs are new to Eskenazi Health upon our move to the new facility. Policy 950-126 will be revised to reflect weekly defib firings and unit checklists throughout the organization will be revised to be reflective of Philips checklist recommendations to be conducted each shift. The Clinical Nurse Specialist for the ICU will be responsible for making the policy changes. The Safety Committee will discuss any trends or identification of non-compliance with the policy changes during their monthly meetings. Issues warranting attention will be forwarded to the CNO for further follow-up. The CNO will be ultimately responsible for ongoing compliance with the associated change in policy/procedure. The policy will go to the Administrative Policy and Procedure Committee on July 24, 2014. Education will be completed by the ICU CNS and the Clinical Education Department following the policy approval.</p>				

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S001172	<p>6. Review of a document entitled Clinical Services Emergency Checklist Cardiac Diagnostics Department did not indicate which manufacturer's recommended various specific shift checks and tests were to be done. Further review of the document did not indicate reference to the manufacturer's recommendations for the various specific checks to be done each shift.</p> <p>7. Review of a document entitled Emergency Equipment Checklist, Unit: 8W, did not indicate which manufacturer's recommended various specific shift checks and tests were to be done. Further review of the document did not indicate reference to the manufacturer's recommendations for the various specific checks to be done each shift.</p> <p>8. In interview on 6-11-14 at 9:40 am, employee #A8 confirmed all the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including</p>				

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	<p>fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, the hospital failed to guard against transmission of disease to patients by using the current principles of cross-infection in 3 instances.</p> <p>Findings:</p> <p>1. On 6-9-14 at 11:45 am, in the presence of employee #A2 and #A4, it was observed in Room H1-328, radiology patient gowning area, there was considerable dust on the top of the storage on the lockers.</p> <p>2. On 6-9-14 at 12:05 pm, in the presence of employee #A2 and #A4, it was observed in the nuclear medicine room, there was considerable dust on the gamma camera used for patient exams.</p> <p>3. On 6-9-14 at 3:10 pm, in the presence</p>	S001172	The Chief Operating Officer discussed the EVS challenges, specifically dust on high level surfaces and equipment during an organizational Directors Meeting on June 19,2014. The discussion focused on the dust in the new facility being an ongoing challenge and the focus on areas moving toward a proactive approach. The manager of infection prevention and control began weekly meetings with EVS leadership during the week of June 16th, 2014 to co-develop strategies to address the dust concerns within all areas of the new inpatient facility. One of the concerns noted was in the actual determination of which team cleans what areas and /or equipment. Determination made that EVS is responsible for any articles that are not clinical. Examples include cabinet tops, cabinet counters, shelving,	07/28/2014

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	of employee #A2 and #A4, it was observed in the mammography hallway, there was considerable dust on the top of the storage lockers.		and locker surfaces. Clinical staffs from all units are responsible for the cleaning/dusting of clinical equipment/supplies. This information was discussed in multiple forums during June/July 2014, to include a patient safety call, Quality Council, Cleanliness Task Force meeting, and unit based staff meetings. The specific non-clinical areas noted in the deficiency for this tag were cleaned by the night shift EVS crew on June 10th, 2014. The clinical equipment, the gamma camera, was cleaned by a clinical staff member during the morning of June 11th,2014. Moving forward the responsibility for non-clinical equipment and supplies lies with the Director of EVS. The responsibility for the cleanliness of clinical equipment and supplies for various clinical units is with the clinical directors of these units.	