

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150001	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/09/2015
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NAME OF PROVIDER OR SUPPLIER  JOHNSON MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 W JEFFERSON ST FRANKLIN, IN 46131
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S000000	<p>This visit was for a State complaint survey.</p> <p>Complaint Number: IN00158396 Substantiated; State deficiency related to allegations is cited</p> <p>Survey Date: 1-9-15</p> <p>Facility Number: 005001</p> <p>Surveyor: Jack I. Cohen, MHA Medical Surveyor</p> <p>QA: cloughlin 02/09/15</p>	S000000		
S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review, observation and interview, the hospital created 2 conditions which failed to provide a</p>	S000554	S554 Plan of Correction Findings 1 & 2 have been addressed by changing Environmental Services policy to specifically require	03/06/2015

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>healthful environment that minimized infection exposure and risk to patients, employees and visitors.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled CLEANING FLOORS, Reviewed/Revised 11/14/13, indicated to clean floors by dust mopping and to pick up debris with the dustpan and counter brush.</p> <p>2. On 1-9-15 at 11:55 am, in the presence of employee #A2, Chief Nursing Officer, and employee #A3, Laboratory Manager, it was observed in Room 2 of the outpatient lab draw area, there were the following items on the floor:</p> <ul style="list-style-type: none"> <li>1 unopened package of an alcohol prep pad</li> <li>1 sheath from a needle cover</li> <li>1 cotton ball</li> <li>1 inner core from a roll item such as tape</li> </ul> <p>3. In interview, on 1-9-15 at 11:45 am, employee #A4, a hospital phlebotomist, indicated a urine specimen cup, having been placed on a counter in the Outpatient Lab Draw Rooms, would be placed in a plastic bag prior to transportation to the Laboratory. The</p>		<p>sweeping and mopping of the Lab blood draw area floor as part of daily "policing" activity. This correction is evidenced by attachment "S554 Env Serv policy.pdf" section marked "Policing". To ensure this correction is effective daily rounding of the Lab blood draw area is being done by Mike Pryor, Environmental Services Manager, and Jane Alexander, Laboratory Supervisor. This rounding started on 01/12/2015, is done every weekday and will continue until at least 06/30/2015. This rounding is evidenced by attachment "S554 Rounding Log.pdf" which is initialed daily by Mike Pryor and Jane Alexander as they complete their inspection rounds. Finding 3 has been addressed by a policy change to require a urine specimen to be placed in a bio-hazard bag immediately after collection and placed in a designated container. Further, staff are directed by existing policy to clean counter tops as necessary to decontaminate after spills. These corrections are evidenced by attachments "S554 Urine Collections policy.pdf" section I.A.4 and "S554 Counter Cleaning policy.pdf". Notification of the requirements and procedure change has been provided to all clinical staff by Laboratory Supervisor, Jane Alexander as evidenced by attachment "S554 Urine Collections Email.pdf". The</p>		

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	<p>employee did not indicate the counter was wiped down with a disinfectant after placing the specimen cup in a plastic bag.</p> <p>It could not be determined when the counter was disinfected after urine samples had been placed on the counter.</p>		<p>container used for urine specimens is pictured in attachment "S554 Specimen Container.pdf". This container will be wall mounted using amounting bracket which has been ordered as of 2/25/15. The container will be mounted and in use by 3/06/15. The Laboratory Manager will be the responsible person for ensuring compliance with this plan of correction.</p> <p>Respectfully submitted, William Mink, RN Quality Manager Johnson Memorial Hospital</p>		