

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
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NAME OF PROVIDER OR SUPPLIER ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
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S 000 Bldg. 00	The visit was for a licensure survey. Facility Number: 005050 Survey Date: 5-11/12-15 QA: cjl 05/21/15	S 000		
S 322 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (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: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and interview, the governing board failed to implement its policy related to the annual review of policies, in that the policies authored by the infection preventionist lacked an annual review, as required and failed to follow its policy/procedure and	S 322	Corrective Action: Infection Prevention policies have been updated and approved. EVS policies have been updated and will be presented for discussion and approval at the next Infection Prevention Committee meeting. Preventing Recurrence: All polices are set on an annual	07/23/2015

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>ensure that all policy/procedures were updated and/or reviewed annually for 6 of 6 environmental services (EVS) policy/procedures provided for review.</p> <p>Findings:</p> <p>1. The administrative policy titled Annual Policy Review (approved 3-14), policy stat number 796717, indicated the following: "Annually all policies will be reviewed by the respective departments ...the review of policies will be documented in PolicyStat. The revision of policies will be documented in meeting minutes and subsequently in PolicyStat."</p> <p>2. Review of the following policies indicated:</p> <p>a. "Transmission (Isolation) Precautions", policy stat ID 673474 was last approved and revised on 01/2014, with an "expires" date of 01/2016.</p> <p>b. "Screening Visitors to Prevent the Spread of Communicable Illnesses", policy stat ID 573761 was last approved and revised on 10/2013, with an expiration date of 10/2015.</p> <p>c. "Hand Hygiene", policy stat ID 673462 was last approved and revised on 01/2014 and expires on 01/2016.</p> <p>d. "Performing An Outbreak Investigation", policy stat ID 603934, was last approved and revised on</p>		<p>review schedule through PolicyStat. All EVS policies will be reviewed on an annual basis through the Infection Prevention Committee. Responsible Persons: Infection Preventionist and EVS Manager Correction Date: Infection Prevention policy review cycle was updated 5/18/15. EVS policies will be reviewed at the next Infection Prevention Committee Meeting on 7/23/15.</p>	

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	<p>10/2013, with an "expires" date of 10/2015.</p> <p>3. At 1100 hours on 5/12/15, interview with staff member #51, the chief nursing officer, indicated:</p> <p>a. After on line review of the policies listed in #2 above, it was noted that the previous infection preventionist had failed to set the policy stat program to an annual review prompt.</p> <p>b. The policies, as listed in #2 above, were not reviewed annually, as required by the "Annual Policy Review" policy (listed in 1. above).</p> <p>4. The administrative policy titled Annual Policy Review (approved 3-14) indicated the following: "Annually all policies will be reviewed by the respective departments ...the review of policies will be documented in PolicyStat. The revision of policies will be documented in meeting minutes and subsequently in PolicyStat."</p> <p>5. On 5-12-15 at 0930 hours, the compliance officer A2 was requested to provide copies of EVS policy/procedures for standard occupied and terminal patient room cleaning, occupied and terminal contact isolation patient room cleaning including the specific process and disinfecting products for use with methicillin-resistant staph aureus (MRSA)</p>			

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	<p>and Clostridium difficile (C dif) organisms, and terminal operating room (OR) cleaning by EVS staff.</p> <p>6. During an interview on 5-12-15 at 1115 hours, the chief nursing officer A1 indicated that the corporate network EVS provider was not utilizing the available network PolicyStat system.</p> <p>7. The policy/procedures titled 7.01 Standard Room Cleaning Procedure (Healthcare), 7.02 Discharge Room Cleaning Procedure, 7.04 Occupied Isolation Room Cleaning Procedure, 7.05 Isolation Discharge Room Cleaning Procedure, and 7.06 Interactive Room Cleaning Procedure failed to indicate the correct name of the corporate EVS provider in use since 2011 and failed to indicate any policy had been reviewed within the past three years. The policy/procedure 9.01 Surgery Cleaning failed to indicate a review or revision had been performed since 2013.</p> <p>8. During an interview on 5-12-15 at 1340 hours, the EVS manager A18 and EVS director A19 confirmed that the EVS policy/procedures had not been updated and/or reviewed annually in accordance with the hospital policy on policies and confirmed that no other documentation was available.</p>			

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S 330 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review and interview, the governing board failed to ensure that the tuberculosis control plan was implemented, in relation to an annual risk assessment.</p> <p>Findings: 1. Review of the "Tuberculosis Control Plan", policy stat number 797574, last approved and revised on 04/2014, indicated: a. On page two, under "Hierarchy of Control Measures", it reads: "A.</p>	S 330	<p>Corrective Action: Infection Prevention and Associate Health has completed the yearly tuberculosis risk assessment. Preventing Recurrence: The tuberculosis risk assessment will be added to the Tuberculosis Control Plan Policy as an attachment in PolicyStat. The Risk Assessment will be reviewed and approved annually with the Tuberculosis Control Plan Policy. Responsible Persons: Infection Preventionist and Associate Health Nurse Date: The Risk Assessment will</p>	07/23/2015

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S 332	<p>Administrative Controls 1. Assignment of Responsibility a. The Infection Prevention Department, under the guidance of the Infection Prevention Committee, is assigned responsibility for the TB (tuberculosis) Plan...2. Risk Assessment a. An annual risk assessment is performed in collaboration with the OAH (office of associate health) and will be presented as part of the overall Infection Control Plan...".</p> <p>2. Review of the most recent TB risk assessment indicated this was done from 2012 data for 2013 implementation.</p> <p>3. At 12:30 PM on 5/12/15, interview with staff member #51, the chief nursing officer, indicated:</p> <p>a. A risk assessment was not completed regarding 2013 data for implementation in 2014.</p> <p>b. A risk assessment for implementation in 2015 has not been completed.</p> <p>c. The 2012 TB risk assessment was the last one completed for the facility.</p> <p>d. The "Tuberculosis Control Plan", listed in 1. above, was not followed.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD</p>		be reviewed at the next Infection Prevention Committee Meeting on 7/23/15.		

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Bldg. 00	<p>410 IAC 15-1.4-1(c)(6)(L)</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>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and interview, the facility failed to ensure personnel files for environmental services (EVS) staff including documentation of training in effective housekeeping procedures and personnel competency for cleaning and disinfecting were maintained and available for review for 1 (A20) contracted EVS personnel.</p> <p>Findings:</p> <p>1. The Association of periOperative Registered Nurses (AORN) publication titled Recommended Practices for Environmental Cleaning (2014) indicated the following: "Recommendation VIII.a. Perioperative and environmental services personnel must receive education and complete competency verification activities that address specialized knowledge and skills related to the</p>	S 332	<p>Corrective Action: New EVS staff has been hired to fill the vacancy. Personnel files for all EVS staff are now located in the EVS Manager's office in this facility. The policy for terminal cleaning has been revised to reflect appropriate cleaning procedure. The policy will be presented at the next Infection Prevention Committee meeting for discussion and approval. All EVS Staff have been educated on this policy. All EVS Staff are undergoing weekly education and competency verification on a weekly basis, which will continue until all competencies are updated. OR Terminal cleaning competency has been completed for the EVS staff member assigned to Surgery on 6/10/15. Documentation of competency has been place in her personnel file.Preventing Recurrence: EVS Manager, Infection Preventionist and Surgery Nurse Manager will</p>	07/23/2015

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	<p>principles and processes of environmental cleaning."</p> <p>2. On 5-11-15 at 1050 hours, the compliance officer A2 and administrator A10 were requested to provide a personnel file including documentation of competency for the EVS staff providing services in the restricted surgical environment and none was provided prior to exit.</p> <p>3. During an interview on 5-11-15 at 1135 hours, surgery manager A16 indicated that the contracted EVS provider had experienced a staff vacancy for terminal cleaning of the surgical areas and indicated that an EVS staff A20 has been commuting from another network facility to perform terminal cleaning in the surgery department.</p> <p>4. During an interview on 5-12-15 at 1405 hours, the EVS manager A18 indicated that the personnel file for staff A20 was located at another network facility and indicated that no staff at the network location were available to obtain the personnel file for surveyor review. The EVS manager A18 confirmed that the personnel file lacked documentation of staff competency for terminal operating room cleaning.</p>		<p>spot check the EVS staff and visually inspect the OR rooms with report of these checks being presented in Infection Prevention Committee Meetings. Responsible Persons: EVS Manager, Infection Preventionist and Surgery Nurse Manager Correction Date: EVS Terminal Cleaning Policy was revised on 6/8/15. Annual education of EVS staff was started the week of 6/8/15. Reports to the Infection Prevention Committee will begin with the next Committee Meeting on 7/23/15.</p>	

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S 592 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(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>(i) Sanitation. Based on document review, observation, and interview, the infection control committee failed to document the oversight of housekeeping staff and failed to approve of products found in one janitorial closet.</p> <p>Findings: 1. Review of the "Infection Prevention Surveillance Program (IPSP)", approved 9/11/14, indicated: a. Under "Scope", it reads: "The scope of the IPSP extends to all departments in the hospital and includes all persons who obtain services, are employed, contracted or are performing internships or volunteer at our facility. The principal</p>	S 592	<p>Corrective Action: All cleaning products will be approved by the Infection Prevention Committee. Any new cleaning product will be presented and approved by the Infection Prevention Committee prior to being placed into the EVS closets or carts. All EVS staff have been re-educated on all cleaning products and their usage. All EVS policies will be approved by the Infection Prevention Committee for oversight of EVS procedures. Preventing Recurrence: Any new cleaning product will be approved by the Infection Prevention Committee before being placed into the EVS closets or carts. The list of cleaning products will be included</p>	07/23/2015
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	<p>goals of the program are to 1) protect those in the healthcare environment by preventing the transmission of infectious agents by surveillance, intervention and education...".</p> <p>2. Review of the policy "Hospital Approved Disinfection Products", no policy number, origination date of 2005 and last review date of 2/2014, indicated:</p> <p>a. The "Policy" states: "New products for disinfection shall be approved by the Infection Prevention Committee and applicable departments."</p> <p>b. 16 products were listed on the policy as approved by the infection control committee.</p> <p>3. At 11:30 AM on 5/11/15, while on tour of the medical/surgical nursing unit in the company of staff members #51, the chief nursing officers, and #53, the med/surg manager, it was noted in the janitor's closet that there was a jug (one gallon, or more) of Diversey Neutral cleaner.</p> <p>4. At 10:15 AM on 5/12/15, interview with housekeeper #59 indicated that this staff member does not use Diversey neutral cleaner and is unsure why it is in the janitor closet.</p> <p>5. At 10:30 AM on 5/12/15, interview</p>		<p>in an Infection Prevention policy that will be reviewed annually by the Infection Prevention Committee. The list of cleaning products will be reviewed and/or revised during the annual policy review. Responsible Persons: Infection Preventionist and EVS Manager Correction Date: The list of cleaning products was updated on 6/11/15. The list and policy will be presented, discussed and approved at the next Infection Prevention Committee Meeting on 7/23/15.</p>	

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	<p>with staff member #54, the infection preventionist, indicated:</p> <p>a. It is not known by this staff member where the Diversey neutral cleaner is used in the facility.</p> <p>b. The neutral cleaner is not on a list of products approved for use in the facility.</p> <p>c. The EVS (environmental services) staff are not monitored by the infection preventionist, or the infection control committee, in assuring that appropriate products are used to clean and sanitize the facility.</p> <p>d. The policy listed in 2. above does not indicate where each product is to be used (what surface/surfaces), how to mix (if needed), the appropriate dwell time, etc.</p> <p>6. During an interview on 5-12-15, at 1:40 PM, the EVS manager A18, and EVS director A19, confirmed that:</p> <p>a. The EVS policy/procedures had not been approved by the facility infection control committee.</p> <p>b. The cleaning products listed in the approved disinfection products policy lacked information regarding what surfaces to use the products on, how to mix (if needed), the appropriate dwell time, etc.</p> <p>c. The contracted cleaning company has not been working with the infection preventionist to coordinate cleaning products, cleaning expectations, and</p>			

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S 606 Bldg. 00	<p>cleaning processes for the company to implement at the facility.</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 document review and interview, the infection control committee failed to ensure an effective health program related to the lack of knowledge of communicable disease history for 4 of 12 employees (staff members N2, N5, N6 and N8).</p> <p>Findings: 1. Review of the policy "Pre-Placement (Post-Offer) Physical Examinations", policy stat number 1017693, with an</p>	S 606	<p>Corrective Actions: All staff medical charts have been reviewed for immunization completeness. All stated Varicella histories will be replaced with laboratory titers.Preventing Recurrence: All new hires will have a completed immunization history in the associate medical file in the Associate Health Office. Associate Health Nurse will follow up with any staff needing titers.Responsible Person: Associate Health NurseCorrection Date: Review of</p>	07/10/2015

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	<p>effective date of 09/2010, and last approved on 11/2014, indicated:</p> <p>a. Under the section "Procedure", it reads in section D. "Screening Tests for Immunity to Communicable Illnesses, Measles, Mumps, Rubella and Varicella": "Evidence of immunity is required for healthcare workers,...Acceptable documentation shall be provided by the candidate of appropriate vaccination, laboratory evidence of immunity or laboratory confirmation of communicable diseases listed herein..."</p> <p>2. Review of personnel health files indicated:</p> <p>a. RN (registered nurse) N2 was hired 8/29/01 and had a self reported history of having had Chickenpox (Varicella) as a child.</p> <p>b. LPN (licensed practical nurse) N5 was hired 11/2/04 and had a self reported history of having had Chickenpox (Varicella).</p> <p>c. LPN N6 was hired 4/8/02 and had a self reported history of having had Chickenpox (Varicella), and a 10/5/05 lab result for Varicella that was "Equivocal" with no follow up done.</p> <p>d. RN N8 was hired 2/5/96, had no Rubeola documentation, and had a self reported history of having had Chickenpox (Varicella).</p>		<p>all staff medical charts was completed on 6/11/15. Follow up with staff will be completed by 7/10/15.</p>	

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S 912 Bldg. 00	<p>3. At 12:50 PM on 5/12/15, interview with staff member #58, the employee health nurse, indicated:</p> <p>a. The policy regarding immunization history (listed in 1. above) was implemented in 2010, but none of the employees hired prior to 2010, who self reported having had Varicella as a child, were checked to see what their immunization status actually was, leaving the facility at risk for a possible outbreak due to the lack of this information.</p> <p>b. Staff member N6 had an equivocal (meaning unknown status) Varicella that should have been followed up on, but there is no documentation indicating this was done.</p> <p>c. There is no Rubeola documentation for staff member N8.</p> <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,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
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	<p>determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital.</p> <p>(ii) Maintaining a current nursing service organization chart.</p> <p>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.</p> <p>(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.</p> <p>(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 document review, observation, and interview, the nursing executive failed to ensure that nursing staff implemented policies related to: the dating of glucometer control solutions, and the measuring and documentation of pediatric head circumference in 1 of 2 children less than 2 years of age (Pt. # 12).</p> <p>Findings:</p> <p>1. Review of the policy "Blood Glucose by Accucheck Advantage Meter", policy stat number 596017, last approved on 10/2013, indicated:</p> <p>a. Under "Reagents", it reads: "...B. Accucheck Comfort Curve Control Solutions, Level 1 and Level 2. When a</p>	S 912	<p>Corrective Action: The open date will be documented on the glucometer control solution with a permanent marker. The date will then be covered with clear tape to prevent smudging. Pediatric head circumference will be measured and documented on all pediatric patients who are 2-years-old or younger. Preventing Recurrence: All Nursing Managers will make periodic checks on the glucometer control solutions. If the above procedure is not followed, nursing staff will be re-educated. Med/Surg Nursing Manager will check all pediatric charts for documentation of head circumference for the next three (3) months or until reaching 100% compliance. Any charts found without the appropriate</p>	05/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151301	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
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NAME OF PROVIDER OR SUPPLIER ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
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	<p>new bottle of glucose control solution is opened, write the date opened on the label. Control solutions expire at 90 days after opening or the bottle's expiration date, whichever comes first. Write the expiration date on the bottles."</p> <p>2. At 11:35 AM on 5/11/15, while on tour of the medical/surgical nursing unit in the company of staff member #53, the med/surg manager, it was observed that the dates the control solutions (level 1 and level 2) had been opened was smudged off so that it could not be determined when the 90 day expiration date might occur.</p> <p>3. At 11:40 AM on 5/11/15, interview with staff member #53, the med/surg manager, indicated the open dates on the control solutions were illegible.</p> <p>4. At 1:25 PM on 5/11/15, while on tour of the ED (emergency department) Triage room, it was observed that the dates the control solutions (level 1 and level 2) had been opened were smudged off so that it could not be determined when the 90 day expiration date might occur.</p> <p>5. At 2:15 PM on 5/11/15, interview with staff member #56, the ED manager, indicated the open dates on the control solutions were illegible.</p>		<p>documentation will be re-educated with corrective action, if necessary. Responsible Persons: Glucometer Control Solution dating – All Nursing Managers. Pediatric Head Circumference – Med/Surg Nursing Manager Correction Date: Education for glucometer control solution dating was completed on 5/26/15 and 5/27/15. Re-education on documenting head circumference was completed on 5/26/15 and 5/27/15.</p>	

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NAME OF PROVIDER OR SUPPLIER ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
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	<p>6. At 2:10 PM on 5/11/15, while on tour of the OB (obstetrics) unit in the company of staff member #55, the OB manager, it was observed that the open date on the control solutions (level 1 and level 2), was 3/9/15, but lacked notation of the 90 day expiration date.</p> <p>7. Review of the policy "Documentation - Pediatric", policy stat number 918453, last approved 06/2014, indicated:</p> <p>a. Under the section "Implementation & Documentation", on page 4., in the section C. "Graphic Record", it reads: "...3. If appropriate to the patient's condition record the patient's weight, abdominal circumference and head circumference by writing the data in the appropriate boxes..."</p> <p>8. Review of two closed pediatric patient medical records (#12 and #15), of those less than 2 years of age, indicated that patient #12 was a 1 year old admitted on 3/31/15 who lacked documentation of having a head circumference measured on admission.</p> <p>9. At 2:00 PM on 5/12/15, interview with the med/surg manager, staff #53, indicated:</p> <p>a. Thorough review of the on line medical record for pt. #12 indicated there</p>			

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S 118 Bldg. 00	<p>was no documentation for a head circumference measurement.</p> <p>b. The pediatric policy was not followed in regard to pt. #12 with the lack of measurement/documentation of a head circumference.</p> <p>c. The policy does not specify, but the expectation for measuring a head circumference, is for patients less than 2 years of age.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on documentation review, observation and interview, the facility failed to maintain all equipment in good working order and guard against transmission of disease for one ice machine.</p>	S 118	<p>Corrective Action: All ice machines have been cleaned. EVS staff will clean the ice machines every week. Documentation of cleaning will be on a paper chart with each ice machine. All documentation will be collected by the EVS manager. All ice machines will</p>	05/18/2015

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	<p>Findings:</p> <ol style="list-style-type: none"> 1. The manufacturer's instruction manual (issued 11-15-2013) for a Hoshizaki DCM-270BAH Icemaker/Dispenser indicated the following: "Every six months...Icemaker and Storage Bin...clean and sanitize per the cleaning and sanitizing instructions provided in this manual." 2. Review of facility maintenance documentation on 5-11-15 at 1345 hours indicated icemaker preventive maintenance was scheduled to be performed annually and was last performed on 4-2014 for the equipment. 3. During an observation on 5-11-15 at 1510 hours, the following condition was observed in the medical-surgical nursing unit pantry area: a Hoshizaki tabletop ice machine with areas of dark brown-colored surface residue (suspected mold) in the dispensing outlet of the ice machine. 4. During an interview on 5-11-15 at 1510 hours, the compliance officer A2 and the facilities manager A5 confirmed the presence of the brown-colored residue and confirmed that the ice machine had not been maintained. 		<p>undergo a preventative maintenance procedure performed by Facilities Staff every six (6) months.Preventing Recurrence: Documentation of cleaning will be on a paper chart with each ice machine. All documentation will be collected by the EVS Manager. All machines will undergo a preventative maintenance procedures performed by Facilities Staff every six (6) months.Responsible Persons: EVS Manager/ Facilities ManagerCorrection Date: Preventative maintenance was performed by Facilities Staff on 5/12/15. Weekly cleaning began the week of 5/18/15.</p>	

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S 126 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(C)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Maintenance and repairs shall be carried out in accordance with applicable codes, rules, standards, and requirements of local jurisdictions, the administrative building council, the state fire marshal, and the department.</p> <p>Based on document review and interview, the facility failed to ensure that operating room (OR) ventilation including the total number of air exchanges per hour was properly maintained for 1 of 2 operating rooms (OR 2) at the facility.</p> <p>Findings:</p> <p>1. The American Institute of Architects (2001 edition) Guidelines for Design and Construction of Hospital and Health Care</p>	S 126	<p>Corrective Action: Facilities Staff will change the air filters for the rooftop unit that services the Surgery Department. Vendor Total Balance will inspect and correct air exchanges further. Preventing Recurrence: Air exchanges will be inspected and tested on an annual basis. Responsible Person: Facilities Manager Correction Date: Air filters were changed on 6/10/15. Total Balance will inspect and service the unit on 6/19/15 to insure full compliance of the system and such</p>	06/19/2015

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	<p>Facilities indicated the following: "Table 7.2: Ventilation Requirements for Areas Affecting Patient Care in Hospitals and Outpatient Facilities...Operating/surgical cystoscopic rooms...Minimum total air changes per hour: 15."</p> <p>2. On 5-12-15 at 1020 hours, facility documentation dated 3-3-14 of OR air exchange testing and certification for OR 1207B (OR2) indicated the total number of supply side air changes per hour (ACH) was 14.5 ACH and indicated the return side total air changes per hour was 13.2 ACH.</p> <p>3. During an interview on 5-12-15 at 1030 hours, facilities supervisor A8 confirmed that the most recent documentation of OR air exchange testing for OR 2 failed to meet the minimum number of ACH for compliance with the requirement.</p>		documentation will be forwarded as an addendum to this report.	