| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150175 | | 01/27/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| S 000<br>Bldg. 00 | This visit was for a State licensure survey.<br><br>Facility Number: 011772<br><br>Dates: 01/26/15 to 01/27/15<br>Surveyors:<br>Trisha Goodwin, RN BS<br>Public Health Nurse Surveyor<br><br>Jennifer Hembree, RN<br>Public Health Nurse Surveyor<br><br>Ken Ziegler, MT MS<br>Medical Surveyor III<br><br>QA: claughlin 02/20/15 | S 000 | | |
| S 308<br>Bldg. 00 | 410 IAC 15-1.4-1<br>GOVERNING BOARD<br>15-1.4-2 (c)(6)(B)<br><br>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:<br>(6) Require that the chief executive officer develops policies and programs | | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | for the following:<br><br>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.<br>Based on document review and interview, the chief executive officer (CEO) failed to develop policies and programs (P&P) for orientation of contracted personnel to department policies.<br><br>Findings:<br><br>1. Review of contracted personnel files P1, P2, P3, P4, P5, P6, P8, & P9 lacked documentation of orientation to the facility department P&P.<br><br>2. On 1/27/14 at 4:00pm, A13 indicated the facility did not provide orietnation specific to the facility for contracted staff and they did not have a P&P for this topic. | S 308 | **S308 – Governing Board** Based on document review and interview, the chief executive officer (CEO) failed to develop policies and programs (P&P) for orientation of contracted personnel to department policies. **Findings include: 1.** Review of contracted personnel files P1, P2,P3, P4,P5, P6, P8 and P9 lacked documentation of orientation to the facility department P&P. **Correction Plan:** Education will be launched to all current DH employees who could potentially be assigned to work within the Heart Hospital. Additionally, this Onboarding will be assigned to all new employees of Deaconess Hospital. **Recurrence Prevention**: Once the education is assigned to all current and future staff the responsibility to complete the lesson will lie with the employee. If an employee fails to complete assigned lessons in Web Inservice they will be subject to disciplinary action under P&P 45-19 Standards of Employee Conduct for failure to meet the requirements of the job. **Responsible Person(s):** Human Resources Manager **Completion Date**: 4/30/15 **2.** | 04/27/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150175 | | 01/27/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | On 1/27/2014 at 4:00 pm, A13 indicated the facility did not provide orientation specific to the facility for contracted staff and they did not have a P&P for this topic. **Correction Plan: (NOTE:** There was no request to producea P&P that addresses contracted staff facility orientation requirements.) P&P 45-13S DHS Employment Process, addresses the topic of On Boarding to be completed within 30 days of hire. The policy will be reviewed and revised to reflect the scope of On Boarding. It will be broadened to reflect OB at The Heart Hospital and the potential to be assigned to the facility within the GW campus. **Recurrence Prevention**: According to P&P 45-13S, DHS Employment Process, Human Resources will insure new hires complete On Boarding within 30 days of hire. **Responsible Person(s):** Human Resources Manager **Completion Date:** 4/27/15 | |
| S 392<br><br>Bldg. 00 | 410 IAC 15-1.4-1<br>GOVERNING BOARD<br>410 IAC 15-1.4-1(f)(2)<br><br>(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:<br><br>(2) That the services performed under a contract are provided in a safe and effective manner and are included in | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 4007 GATEWAY BLVD NEWBURGH, IN 47630 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the hospital's quality assessment and improvement program. | | | |
| | Based document review and interview, the governing board (GB) failed to ensure services performed under contract were included in the quality assessment and performance improvement program (QAPI) for 7 contracted services (biohazardous waste hauler, computed tomography (CT) scan, trans-esophogeal echocardiogram (TEE), laundry, magnetic resonance imaging (MRI), tissue transplant, and ultra sound (US).<br><br>Findings:<br><br>1. Review of 2014 QAPI meeting minutes and reports lacked documentation of including the following contracted services: biohazardous waste hauler, CT scan, TEE, laundry, MRI, tissue transplant, & US.<br><br>2. On 1/27/15 at 5:00pm A8, Quality Regulator, confirmed lack of QAPI documentation for the above and no further documentation was provided prior to exit. | S 392 | **S 392 – Governing Board**<br>Based on document review and interview the governing board(GB) failed to ensure services performed under contract were included in the quality assessment and performance improvement program (QAPI) for 7 contracted services (a) biohazard waste hauler, b) computed tomography (CT) scan, c) trans-esophageal echocardiogram (TEE), d) laundry, e) magnetic resonance imaging (MRI), f) tissue transplant and g) ultrasound (US). Findings include: 1. Review of 2014 QAPI meeting minutes and reports lacked documentation of including following contracted services, biohazardous waste hauler, CT scan, TEE,laundry, MRI, tissue transplant and US.<br>**Correction Plan:** a) *Biohazard waste hauler* is a purchased service provided by the DH Environmental Service Department material handlers. Metrics for this specific service has been added to the Contracted Services Dashboard.<br>b) *Computed tomography* is a purchased serviceprovided by the DH Radiology department. Metrics for anatomy imaging accuracyand correct marker selection and placement have been tracked by THH since 2009.Additional metrics will be added to the Contracted Services | 02/27/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | Dashboard forradiology. c) *Trans-esophageal echocardiogram (TEE)*studies are performed by in the Non-Invasive Department at The Heart Hospital.Therefore, it is not a contracted service that will be added to the ContractedServices Dashboard. However, departmental metrics are tracked. d) *Laundry* is a purchased service provided by the DH Laundry. Metrics have been added to Contracted Services Dashboard. e) *Magnetic resonance imaging* is a purchased service provided as needed by the DH Radiology department. Metrics for anatomy imaging accuracy and correct marker selection and placement have been tracked since 2009. Additional metrics will be added to the Contracted Services Dashboard for radiology. f) *Tissue Transplant* – The Heart Hospital does not perform tissue transplants. Heart valves are purchased from a vendor.The serial number, the lot number and additional information is documented in the patients chart for each surgically replaced heart valve. To capture potential concerns, The Heart Hospital records every patient incident that occurs outside the norm. For example, if a patient needs a valve replaced in a time frame shorter than expected the surgery is recorded in the incident management system and investigated individually. This is | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | not a metrics we capture and report on under Contracted Services. It is reported through the Patient Safety Dashboard. g) *Ultrasound* is a purchased service provided as needed by the DH Radiology department. Metrics for anatomy imaging accuracy and correct marker selection and placement have been tracked since 2009. Additional metrics will be added to the Contracted Services Dashboard for radiology. **Recurrence Prevention**: Any addition or deletions to the Contracted Services Dashboard will require the approval of the Strategic Quality Committee and the Governing Board. **Responsible Person(s): Quality, Regulatory and Patient Safety Officer Completion Date**: 2/27/2015 2. On 1/27/2015 at 5:00 pm, A8 Quality, Regulatory and Patient Safety Office reconfirmed lack of documentation for the above and no further documentation was provided prior to the exit. | |
| S 406<br><br>Bldg. 00 | 410 IAC 15-1.4-2<br>QUALITY ASSESSMENT AND IMPROVEMENT<br>410 IAC 15-1.4-2(a)(1)<br><br>(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 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 4007 GATEWAY BLVD NEWBURGH, IN 47630 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | evaluates, but is not limited to, the following:<br><br>(1) All services, including services furnished by a contractor.<br>Based on document review and interview, the quality assessment and performance improvement (QAPI) program failed to include 7 contrated services in its review (biohazardous waste hauler, computed tomography (CT) scan, trans-esophogeal echocardiogram (TEE), laundry, magnetic resonance imaging (MRI), tissue transplant, and ultra sound (US).<br><br>Findings:<br><br>1. Review of 2014 QAPI meeting minutes and reports lacked documentation of including the following contracted services: biohazardous waste hauler, CT scan, TEE, laundry, MRI, tissue transplant, & US.<br><br>2. On 1/27/15 at 5:00pm A8, Quality Regulator, confirmed lack of QAPI documentation for the above and no further documentation was provided prior to exit. | S 406 | **S406 Quality Assessment and Improvement** Based on document review and interview, the quality assessment and performance (QAPI) program failed to include 7 contracted services in its review (biohazardous waste hauler, computed tomography (CT),trans-esophageal echocardiogram (TEE), laundry, magnetic resonance imaging(MRI), tissue transplant, and ultra sound (US). Findings include: 1. Review of 2014 QAPI meeting minutes and reports lacked documentation of including following contracted services, biohazardous waste hauler, CT scan, TEE,laundry, MRI, tissue transplant and US. **Correction Plan:** a) *Biohazard waste hauler* is a service provided by the Environmental Service Department material handlers. Metrics for this specific service has been added to the Contracted Services Dashboard. b) *Computed tomography* is a service provided by the radiology department. Metrics for anatomy imaging accuracy and correct marker selection and placement have been tracked since 2009. Additional metrics will be added to the Contracted Services Dashboard for radiology. c) | 02/27/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | *Trans-esophageal echocardiogram (TEE)*studies are performed by in the non-Invasive Department at The Heart Hospital.Therefore, it is not a contracted service that will be added to the ContractedServices Dashboard. However, departmental metrics are tracked. d) *Laundry* metrics have been added toContracted Services Dashboard. e) *Magnetic resonance imaging* is a service provided as needed by the radiology department. Metrics for anatomy imaging accuracy and correct marker selection and placement have been tracked since 2009. Additional metrics will be added to the Contracted Services Dashboard for radiology. f) *Tissue Transplant* – The Heart Hospital does not perform tissue transplants. Heart valves are purchased from a vendor.The serial number, the lot number and additional information is documented in the patients chart for each surgically replaced heart valve. To capture potential concerns, The Heart Hospital records every patient incident that occurs outside the norm. For example, if a patient needs a valve replaced in a time frame shorter than expected the surgery is recorded in the incident management system and investigated individually. This is not a metrics we capture and report on under Contracted Services. It is reported through | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | the Patient Safety Dashboard. g) *Ultrasound* is a service provided as needed by the radiology department. Metrics for anatomy imaging accuracy and correct marker selection and placement have been tracked since 2009. Additional metrics will be added to the Contracted Services Dashboard for radiology. **Recurrence Prevention**: The Contracted Services Dashboard has been updated. Performance metrics will be reviewed by Strategic Quality Committee, Medical Executive Committee and the Governing Board. **Responsible Person(s):** Quality,Regulatory and Patient Safety Officer **Completion Date**: 2/5/2015 2. On 1/27/2015 at 5:00pm, A8 Quality, Regulatory and Patient Safety Officer confirmed lack of documentation for the above and no further documentation was provided prior to the exit. | |
| S 554<br><br>Bldg. 00 | 410 IAC 15-1.5-2<br>INFECTION CONTROL<br>410 IAC 15-1.5-2(a)<br><br>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.<br>Based on observation, the facility failed to provide an environment that minimized risk in 2 of 2 nutrition pantries. | S 554 | **S 554 Infection Control** Based on observation, the facility failed to provide an environment that minimized risk in 2 of 2 nutrition pantries. Findings include: 1. | 02/27/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Findings include:<br><br>1. During tour of the Short Stay unit beginning at 10:15 a.m. on 1/27/15, the soda dispenser gun in the nutrition pantry was observed hanging inside the sink. The sink had soap and towels available for handwashing.<br><br>2. During tour of the Inpatient unit beginning at 10:45 a.m. on 1/27/15, the soda dispenser gun was observed on a mount within inches of the sink and could be splashed if the sink were to be used for handwashing. The sink had soap and towels available for handwashing. | | During tour of Short Stay unit beginning at 10:15 am on 1/27/2015, the soda dispenser gun in the nutrition pantry was observed hanging inside the sink. The sink has soap and towels available for hand washing. **Correction Plan: D**ispensers have been moved and are no longer immediately adjacent to the sinks. **Recurrence Prevention**: Dispensers have been relocated away from the sinks. **Responsible Person(s):** Nursing Managers **Completion Date:** February 27, 2015 2. During tour of the Inpatient unit beginning at 10:45 am, on 1/27/2015, the soda dispenser gun was observed on a mount within inches of the sink and could be splashed if the sink were to be used for hand washing. The sink had soap and towels available for hand washing. **Correction Plan: D**ispensers have been moved and are no longer immediately adjacent to the sinks. **Recurrence Prevention**: Dispensers have been relocated away from the sinks. **Responsible Person(s):** Nursing Managers **Completion Date:** February 27, 2015 | |
| S 570<br><br>Bldg. 00 | 410 IAC 15-1.5-2<br>INFECTION CONTROL<br>410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E)<br>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 4007 GATEWAY BLVD NEWBURGH, IN 47630 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following:<br>(A) The person directly responsible for management of the infection surveillance, prevention and control program.<br>(B) A representative from the medical staff.<br>(C) A representative from nursing service.<br>(D) A representative from administration.<br>(E) Consultants from other appropriate services within the hospital, as needed.<br>Based on document review and interview, the facility failed to ensure the infection control committee had membership that included a representative from nursing service for 5 of 5 meetings held in 2014 and failed to ensure membership included a representative from nursing service and administration for 1 of 1 meeting held in 2015.<br><br>Findings include:<br><br>1. Review of infection control meeting minutes for meetings held on 4/2/14, 7/2/14, 9/10/14, 11/5/14, and 12/3/14 and the membership list, indicated that the infection control committee lacked representation from nursing service. | S 570 | **S570 Infection Control** Based on document review and interview, the facility failed to ensure the infection control committee had membership that a included are presentation from nursing service for 5 of 5 meetings held in 2014 and failed to ensure membership included a representative from nursing services and administration for 1 of 1 meetings held in 2015. Findings include: 1. Review ofthe infection control (IC) committee meeting minutes held on 4/2/2014,7/2/2014, 9/10/2014, 11/5/2014 and 12/3/2014 and the membership list, indicated infection control committee lacked representation from nursing services. 2. Review of infection control meeting minute's membership list for 2015 | 01/28/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 2. Review of infection control meeting minutes and membership list for 2015 indicated the meeting held on 1/7/15 lacked representation and membership from nursing service and administration.<br><br>3. Staff member #1 (Department Manager, Nursing Quality Practice) verified the above in interview at 2:50 p.m. on 1/26/15. | | indicated the meeting held on 1/7/2015 lacked representation and membership from nursing service and administration. 3. Staff member #1 (Department Manager, Nursing Quality Practices verified the above I interview at 2:50 pm, on 1/26/2015 **Correction Plan:** The Deaconess Heath System Infection Control Committee Meetings (which includes The Heart Hospital) and The Heart Hospital Strategic Quality Committee Meetings were scheduled on the same day,at the same time. The manager responsible for IC was obligated to attend both meetings. The Heart Hospital Strategic Quality Committee meeting schedule has been changed to eliminate this conflict in the manager's schedule. She will now be attending the meetings as the nursing service and administrative representative. The Heart Hospital Medical Director for Infection Control wil continue to attend these meetings as well. **Recurrence Prevention**: The manager will secure an attendee for this meeting in her absence to represent nursing services and administration. **Responsible Person(s):** Nursing Quality and Practice Manager **Completion Date:** 1/28/2015 | |
| S 608<br><br>Bldg. 00 | 410 IAC 15-1.5-2<br>INFECTION CONTROL<br>410 IAC 15-1.5-2(f)(3)(D)(ix) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 4007 GATEWAY BLVD NEWBURGH, IN 47630 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows:<br>(3) The infection control committee responsibilities shall include, but not be limited to, the following:<br>(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:<br><br>(ix) Requirements for personal hygiene and attire appropriate for work settings.<br>Based on document review and observation, the facility failed to ensure staff members followed the dress code policy for 1 Cath Lab area.<br><br>Findings include:<br><br>1. Facility policy titled "RECOMMENDED PRACTICES FOR CATH LAB ATTIRE" last reviewed/revised 3/21/14 states "5. All personal clothing must be completely covered by the surgical attire.....Personal clothing that extends above the scrub top neckline or below the sleeve of the surgical attire should not be worn."<br><br>2. During observation in the Cath Lab area beginning at 11:15 a.m. on 1/27/15, | S 608 | **S 608 Infection Control** Based on document review and observation, the facility failed to ensure staff members followed the dress code policy for Cath Lab 1 area. Findings include: 1. Facilities policy titled "RECOMMENDED PRACTICES FOR CATH LAB ATTIRE" last reviewed/revised 3/21/2014 states "5. All personnel clothing must be completely covered by the surgical attire…….Personal clothing that extends above the scrub top neckline or below the sleeve of the surgical attire should not be worn." 2. During observation in the Cath Lab area beginning at 11:15 am, on 1/27/2015, staff member #1 (Registered Nurse) was observed in Cath Lab 4 with a t-shirt on under his/her scrub top. The t-shirt sleeves were exposed below the scrub top sleeves and | 02/16/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | staff member #1 (Registered Nurse) was observed in Cath Lab #4 with a t-shirt on under his/her scrub top. The t-shirt sleeves were exposed below the scrub top sleeves and at the neck of the scrub top. | | at the neck of the scrub top.<br>**Correction Plan:** 1. Policy and Procedure CVL-52 Recommended Practices for Cath Lab Attire requirements were reviewed with the staff. Completed 2/25/2015 2. Staff member #1 is purchasing V-Neck T-shirts to wear under his/her scrubs.RN#1 knows t-shirts cannot extend above the neckline of the scrub and or below the scrub sleeves. Projected completion date: 3/5/2015 3.Leadership is evaluating various attire options for Cath Lab staff. Jackets and other scrubs are under review. Projected Completion Date: 3/20/2015<br>**Recurrence Prevention**: Any staff member not adhering to requirements will be counseled.<br>**Responsible Person(s):** Manager, Cardiovascular Laboratory and Quality, Regulatory and Patient Safety Officer **Completion Date:** 2/16/2015 | |
| S 804<br>Bldg. 00 | 410 IAC 15-1.5-5<br>MEDICAL STAFF<br>410 IAC 15-1.5-5(a)(1)<br><br>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients.<br>The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | governing board and do the following:<br><br>(1) Conduct outcome oriented performance evaluations of its members at least biennially.<br>Based on document review and interview, the medical staff (MS) failed to conduct biennial outcome oriented performance evaluations for 2 members (MD#1 & MD#4).<br><br>Findings:<br><br>1. Review of MS credential files lacked documentation of a biennial performance review for MD#1 & MD#4<br><br>2. On 1/27/15 at 4:40pm A2, Manager of MS Services, confirmed credential files for MD#1 & MD#4 lacked documentation of performance evaluations. | S 804 | **S804 – Medical Staff** Based on document review and interview, the medical staff(MS) failed to conduct biennial outcome oriented performance evaluations for 2 members (MD#1 and MD#4). Findings Include: 1. Review of MS credential file lacked documentation of a biennial performance review for MD#1 and MD#4. 2. On 1/27/2015, at 4:40 pm. A2, Manager of MS Services,confirmed credential files for MD#1 and MD#4 lacked documentation of performance evaluations. **Correction Plan:** Quality Dashboards were present in each physician's file. Evidence of biennial reviews for these 2 physicians, as well as all others, is reflected in the Medical Staff Executive Council on 1/15/2015 and Board of Managers meeting minutes dated 1/22/2015. The survey or stated current data does not completely reflect quality outcomes because the number of charts audited and the number of charts that go through the peer review process are not documented. Going forward all physician quality data reports from any source must be submitted on the template provided by The Heart Hospital.Failure to complete the | 03/27/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | document accurately will result in an incomplete application and a suspension of the credentialing or re-credentialing process. **Recurrence Prevention**: All physicians supplementing quality data from a site outside of Deaconess Health System will be given a standard template at the time their application for re-credentialing is submitted biennially. If the requested quality data is not returned, the application will be considered incomplete. **Responsible Person(s):** Manager of Medical Staff Services **Completion Date:** March 27, 2015 | |
| S 872<br>Bldg. 00 | 410 IAC 15-1.5-5<br>MEDICAL STAFF<br>410 IAC 15-1.5-5(b)(3)(P)<br><br>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:<br>(3) include, but not be limited to, the following:<br><br>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.<br>Based on document review and interview, the medical staff failed to complete medical records within 30 days for 4 of 11 medical records (patients #2, 8, 9, and 12). | S 872 | **S 872 – Medical Staff** Based on document review and interview, the medical staff failed to complete medical records within 30 days for 4 of 11 medical records(patients 2, 8, 9 and 12). Findings Include: 1. Medical Staff | 03/27/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Findings include:<br><br>1. Medical Staff By- Laws last approved 4/24/14 states on page 8: ".....A concise discharge summary must be completed on each patient within seven (7) days of patient discharge".<br><br>2. Patient #3 was discharged on 11/10/14 and his/her discharge summary was dictated on 12/25/14.<br><br>3. Patient #8 passed away on 9/8/14 and his/her discharge summary was dictated on 11/2/14.<br><br>4. Patient #9 was discharged on 8/12/14 and his/her discharge summary was dictated on 9/21/14.<br><br>5. Patient #12 was admitted on 8/9/14 and discharged on 8/12/14. His/her medical record lacked a discharge summary.<br><br>6. Staff member #1 (Department Manager, Nursing Quality Practice) verified the above at 3:40 p.m. on 1/27/15. | | By-Laws last approved 4/24/2014 states on page 8: "A concise discharge summary must be completed on each patient within 7 days of patient discharge". 2. Patient#3 was discharge on 11/10/2014 and his/her discharge summary was dictated on 12/25/2014. 3. Patient#8 passed away on 9/8/2014 and his/her discharge summary was dictated on 11/2/2014. 4. Patient#9 was discharged on 8/12/2014 and his/her discharge was dictated on 9/21/2014. 5. Patient#12 was admitted on 8/9/2014 and discharge on 8/12/2014. His/her medical record lacked a discharge summary. 6. Staff member #1 (Department Manager, Nursing Quality Practices) verified the above at 3:30 pm, on 1/27/2015.<br>**Correction Plan:**<br>·Report generated by Medical Records department to flag incomplete discharge summaries by physician.<br>·Physicians will be re-educated regarding discharge summary completion, the requirements outlined in the Medical Staff Bylaws and penalties for failure to comply within the stated seven days post discharge.<br>**Recurrence Prevention**: Completion of discharge summaries will be audited and monitored through reports generated by the Medical Records department and reviewed by the Manager of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150175 | | 01/27/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | Medical Staff Services, findings will be reported to the Executive Director & CNO,President of The Heart Hospital Medical Staff , Medical Staff Executive Council and Board of Managers a on a bi-monthly basis. **Responsible Person(s):** Manager of Medical Staff Services, Executive Director & CNO and President of The Heart Hospital Medical Staff **Completion Date:** March 27, 2015 | |
| S 912<br><br>Bldg. 00 | 410 IAC 15-1.5-6<br>NURSING SERVICE<br>410 IAC 15-15-6 (a)(2)(B)(i)(ii)<br>(iii)(iv)(v)<br><br>(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:<br><br>(2) A nurse executive who is:<br>(B) responsible for the following:<br>(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.<br>(ii) Maintaining a current nursing service organization chart.<br>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.<br>(iv) Ensuring that all nursing personnel meet annual in-service | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | requirements as established by hospital and medical staff policy and procedure, and federal and state requirements.<br>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.<br>Based on document review and staff interview, the facility failed to maintain current job descriptions for 2 of 2 Agency Registered Nurses and 1 of 1 Patient Care Associate (PCA) personnel files reviewed.<br><br>Findings include:<br><br>1. Staff members #N2 and N3 (both Agency Registered Nurses) personnel files lacked evidence of a job description.<br><br>2. Staff member #N8 (PCA) personnel file lacked evidence of a job description.<br><br>3. Staff member #A13 (Human Resources Manager) verified the above in interview at 3:50 p.m. on 1/27/15. | S 912 | **S 912 Nursing Services** Based on document review and staff interview, the facility failed to maintain current job descriptions for 2 of 2 Agency Registered Nurses and 1 of 1 Patient Care Associates (PCA). Findings Include: 1. Staff member#2 and N3 (both Agency Registered Nurses)personnel files lacked evidence of a job description. 2. Staff member #8 (PCA) personnel file lacked evidence of a job description. 3. Staff member A13 (Human Resources Manager) verified the above in interview at 3:50 pm, on 1/27/2015. **Correction Plan:** While the job description has been shared with the Agency, they have been instructed to provide a copy to all candidates prior to interviewing and if selected for placement within THH, it is now part of the compliance packet that must be sent prior to a start date at The Hear tHospital. The compliance packet includes all other items that become the 'shadow personnel file' at THH – items required for compliance purposes. All new hires receive a copy of the job description during | 02/01/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | the department orientation. It is to be reviewed and signed as part of the department orientation upon hire. **Recurrence Prevention**: In addition to the job description becoming part of the compliance packet for all agency nurses, it is part of the review and department orientation upon placement / hire. It will be collected as part of the orientation process. **Responsible Person(s):** The HR Manager and all Department Managers **Completion Date**: Completed 2/1/15. | |
| S 160<br>Bldg. 00 | 410 IAC 15-1.5-8<br>PHYSICAL PLANT<br>410 IAC 15-1.5-8(d)(1)<br><br>(d) The equipment requirements are as follows:<br><br>(1) All equipment shall be in good working order and regularly serviced and maintained.<br>Based on document review and observation, the facility failed to ensure regular service and maintenance for 2 refrigerators.<br><br>Findings:<br><br>1. Review of Policy No. 40-85 S, titled Refrigeration, indicated in IV. Responsibilities: B. Department manager is responsible to assure regualr cleaning is performed at least monthly or | S 160 | **S1160 Physical Plant**<br>Based on document review and observation, the facilityfailed to ensure regular service and maintenance for 2 refrigerators.<br>Findings Include:<br>1. Review ofPolicy No. 40-85 S, titled Refrigeration, indicated in IV. Responsibilities:<br>B.Department manager is responsible to assure regular cleaning is performed atleast monthly or as needed. Defrosting of freezers will be completed asrequired and in V. Procedures: | 01/27/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | as needed. Defrosting of freezers will be completed as required and in V. Procedures: 2. All refrigerator and freezer temperatures are to read and recorded twice daily.<br><br>2. During tour on 1/26/15 between 11:50am and 1:50pm in the bulk supply storage area, in the presence of A4, the Site Manager, the following was observed: 2 refrigerator/freezers both with heavy frost/ice build-up and boxes in the freezer compartments. Upon request for review of cleaning and temperature logs A4 indicated none were available. A4 further indicated the refrigerator/freezers were used for temporary storage of medications and/or supplies. | | 2. all refrigerator and freezer temperatures areto be read and recorded twice daily.<br><br>2. Duringtour on 1/26/2015 between 11:50 am and 1:50 pm in the bulk storage area, in thepresence of A4, the Site Manager, the following was observed: 2refrigerators/freezers both with heavy frost/ice build-up and boxes in freezercompartments. Upon request for review of cleaning and temperature logs A4indicated none were available. A4 further indicated the refrigerators/freezerswere used for temporary storage of medications and/or supplies.<br><br>**Correction Plan:** The refrigerators andfreezers were cleaned on 1/27/2015. Policy and Procedure *40-85 S Refrigeration* was added to the regulatory binder in thematerials department. The refrigerator/freezer temperature log was posted andstaff were trained on the requirements to record temperatures 2x/day.<br>**Recurrence Prevention**: A review of thelogs by the responsible persons listed below.<br>**Responsible Person(s):** Manager,Materials Management and Quality, Regulatory and Patient Safety Officer<br>**Completion Date**: 1/27/2015 | |
| S 166 | 410 IAC 15-1.5-8 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| Bldg. 00 | PHYSICAL PLANT<br>410 IAC 15-1.5-8(d)(2)(C)<br><br>(d) The equipment requirements are as follows:<br>(2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:<br><br>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.<br>Based on document review and interview, it could not be determined that the facility maintained appropriate records pertaining to 2 pieces of equipment (emergency call system & floor scrubber)<br><br>Findings:<br><br>1. From review of 2014 preventive maintenance (PM) logs it could not be determined that records were maintained appropriately. No PM logs were available for the emergency call system and unable to verify quarterly checks of floor scrubber as recommended by the manufacturer or identify for which floor scrubber the checks were being performed.<br><br>2. On 1/27/15 at 1:30pm A4, Site Manager, confirmed PM was not | S 166 | **S1166 Physical Plant**<br>Based on document review and interview, it could not bedetermined that the facility maintained appropriate records pertaining to 2pieces of equipment (emergency Code blue call system) and floor scrubbers).<br>Findings Include:<br>1. Fromreview of 2014 preventive maintenance (PM) logs it could not be determined thatrecords were maintained appropriately. No PM logs were available for theemergency call system (code blue) and unable to verify quarterly checks offloor scrubber as recommended by the manufacturer for which floor scrubberchecks were being performed.<br><br>2. On1/27/2015, 1t 1:30 pm, A4 Site Manager, confirmed PM was not documented for theemergency call system and inability to verify scrubber PM as | 02/27/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150175 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/27/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | documented for the emergency call system and inability to verify floor scrubber PM as indicated above. | | indicated above.<br><br>**<u>Emergency Call System (Code BlueEmergency System)</u>**<br>**Correction Plan:** The emergency callsystem (what we call the code blue system) was not on a pm schedule. An annualinspection for the Code Blue Emergency System, asset # F-04553 was created. ThePM of the entire Code Blue System for The Heart Hospital was created and completed on 2/27/2014 bythe Engineering and Maintenance Department.<br>**Recurrence Prevention**: The PreventiveMaintenance System will generate a work order for the next annual review.<br>**Responsible Person(s):** Site Manager and Quality, Regulatory and Patient Safety Officer<br>**Completion Date**: 2/27/2015<br><br>**<u>Floor Scrubbers</u>**<br>**Correction Plan:** A review of thepreventive maintenance system provided evidence of the annual pm completion forthe floor scrubbers. Last completion date was 12/30/2014. In addition, a copyof the preventive maintenance services completed by Gem Chemical Company, tomeet manufacturer's requirements was also received from the Manager ofEnvironment Services.<br>**Recurrence Prevention**: PMs willcontinue as schedule and copied have ben provide to the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150175 | | 01/27/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEART HOSPITAL AT DEACONESS GATEWAY LLC | 4007 GATEWAY BLVD<br>NEWBURGH, IN 47630 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | Site Manager.<br>**Responsible Person(s):** Site Manager<br>**Completion Date**: 2/27/2015<br>- | |