

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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S 0000 Bldg. 00	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 2/22/2016 to 2/25/2016</p> <p>Facility Number: 005053</p> <p>QA: cjl 03/18/16</p>	S 0000		
S 0320 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD</p> <p>410 IAC 15-1.4-1(c)(6)(G)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</p> <p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee.</p> <p>Based on document review and interview, the facility failed to implement</p>	S 0320	The Director of Total Rewards holds responsibility for the corrective action and ongoing	04/12/2016

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>its policy regarding the provision of a post offer physical examination in consultation with the infection control committee for 5 of 12 (N2, N3, N4, N11 and N12) personnel records reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Policy titled, Post Job Offer Screening Process, revised/reapproved on 5/14 indicated on pg. 1, "All candidates who have been extended an offer of employment with Beacon Health System will be screened post offer and will not start working until all health requirements have been satisfactorily met." 2. Review of personnel records on 2/24/16 at 0935 and 1245 hours, confirmed personnel: <ol style="list-style-type: none"> A. N2, was hired 11/10/14 and lacked documentation of a post offer physical examination. B. N3, was hired 9/8/14 and lacked documentation of a post offer physical examination. C. N4, was hired 5/17/10 and lacked documentation of a post offer physical examination. D. N11, was hired 7/14/14 and lacked documentation of a post offer physical examination. E. N12, was hired 5/28/13 and lacked 		<p>compliance related to the items cited under this tag. The Manager of Employee Health Services and the Director of Total Rewards reviewed the "Post Job Offer Screening Process" policy and the current process for documenting post job offer examinations of new hires. Minor revisions were made to the policy to improve clarity. Revisions include changing the name of the policy to "Post Job Offer Physical Process", adding a baseline Blood Pressure and Heart Rate, and improvement of instruction to the employee if and when they should have a positive TB test at time of hire. The process for documenting post job offer examinations includes the completion of a checklist containing all of the required elements of the post offer examination. The Employee Health files found to be deficient at the time of survey were reviewed again post survey and were found to contain a completed check list documenting these new hires had completed the post offer examination process prior to starting work. As part of the licensure survey process, many different elements of the employee file are reviewed including such items as the job description, performance evaluations, education, licensure and certification, and post offer physical examination. In our large organization, documentation</p>	

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S 0322 Bldg. 00	documentation of a post offer physical examination. 3. Staff N14 (Vice President of Operations) was interviewed on 2/25/16 at approximately 1000 hours and confirmed the above-mentioned personnel lacked documentation of a post offer physical examination as required per facility policy and procedure. Also, the Post Job Offer Screening Process policy does not clearly delineate the elements of the post offer physical examination and all that it will entail.		of these various items is maintained in different departments under the Human Resources umbrella. When a surveyor requests employee files for review, an individual from Human Resources coordinates the efforts to retrieve the various documents from the multiple department files. This individual then compiles all the documentation into a single "employee file" for the surveyor to review. During this process, the Manager of Employee Health Services, who is new to the role, was asked to submit the Employee Health documentation. The Employee Health manager did not include the post hire examination checklist for inclusion in the combined employee file for the surveyor to review. The Manager of Employee Health was educated on the documents which are to be included in a licensure survey review on April 12, 2016. The Director of Total Rewards will ensure appropriate documentation of post job offer physical examinations is provided by confirming with the Employee Health Manager the types of documents to be included upon the surveyor's request for associate files.		
	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)				

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	<p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</p> <p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on observation and interview, the hospital failed to ensure there were policies and procedures for storage and handling of laundry/linen.</p> <p>Findings included:</p> <p>1. During tour of the basement at 2:30 PM on 2/23/2016, in the in-house Laundry Department, the environmental staff were observed washing and drying mops and rags in an industrial washer and dryer. The dry mops and rags were observed in large uncovered transport carts. The rags and mops are used in patient rooms and other patient care areas. The Laundry Department had stored assorted supplies: boxes of paper towels, chemicals, equipment, etc. The ceiling surface and piping that ran along the ceiling were observed with an accumulation of dirt and other debris on them. The uncovered containers of clean rags and mop heads were observed under</p>	S 0322	<p>The Director of Environmental Services holds responsibility for corrective actions and ongoing compliance related to the items cited under this tag. The Director of Environmental Services, in collaboration with Infection Prevention, created new policies "Handling Soiled Linen" and "Linen Management & Distribution" to define appropriate processes related to the specific items cited in the survey. These policies were developed on April 8, 2016. The "Handling Soiled Linen" policy addresses such items as keeping separation from clean linen, containment strategies, cart storage/staging location requirements, PPE requirements and hand hygiene. The "Storage Management and Distribution of Linen" policy outlines clean and soiled linen storage/transport requirements, necessity to keep clean linen covered and storage areas routinely cleaned. Both policies were vetted for approval through both the Infection Control</p>	04/27/2016

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S 0406 Bldg. 00	<p>the dirty ceiling. The shelving units and the floor surface where the clean uncovered rags and mop heads were, were observed to be heavily soiled with an accumulation of soil residue.</p> <p>2. Interview with staff #11 (Environmental Service Supervisor) indicated there were no hospital policies and procedures for laundry/linen handling, storing and distributing.</p> <p>3. In interview at 1:15 PM on 2/24/2016, staff member #2 (Safety and TJC Coordinator) confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to ensure</p>	S 0406	<p>Committee and Hospital Leadership. These policies provide guidance to staff related to the findings cited under this tag. Training of Environmental Services Staff members is ongoing and will be completed in it's entirety by April 27, 2016. Environmental Services Leadership team members are conducting rounding on a regular basis to ensure compliance with new policies.</p> <p>QA/PI is an extremely important topic in our healthcare facility. All of the services that we provide</p>	03/29/2016	

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	<p>nine services were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the Memorial Hospital Performance Improvement Plan stated, "The Hospital Quality and Patient Safety oversees, coordinates, and directs performance improvement activities at Memorial Hospital." The performance Improvement Plan was last reviewed 9/1/2015. Review of the Hospital Quality and Patient Safety Committee dashboards and minutes for 2015 indicated the documents did not evaluate or address the following services: Renal Dialysis, Neurodiagnostic Therapy, Dietetic Services, Medical Records, Physical Therapy, Respiratory Care, Laundry/Linen services, Maintenance and Housekeeping. In interview at 12:30 PM on 2/23/2016, staff member #1 (Director Quality Management) confirmed all the above and no other documentation was provided prior to exit. 		<p>are now required to develop their quality assurance/performance improvement plans and topics annually. This requirement was communicated to the directors over each area on March 29, 2016. Each director over that area is now required to submit to quality and safety the metrics that they are addressing in the current calendar year. On a quarterly basis they will submit documentation of the metrics and an action plan for any metrics that are falling short of their goal targets. This information will be maintained in the office of the VPMA/Chief Safety Officer for Memorial Hospital of South Bend. The VPMA/Chief Safety Officer, who is responsible for the above corrective actions, will ensure ongoing compliance by monitoring the receipt of the quality metrics submitted quarterly from each area.</p>	

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S 0592 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL</p> <p>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 and interview, the infection control (IC) committee lacked documentation indicating IC program oversight and review for the cleaning and disinfecting products used by the environmental services (EVS) personnel and clinical staff at the facility.</p> <p>Findings include:</p> <p>1. The policy/procedure titled Policies &</p>	S 0592	The Director of Environmental Services holds responsibility for the corrective actions and for ensuring ongoing compliance related to the items cited under this tag. The Coordinator of Epidemiology reviewed the Infection Control Plan on April 1, 2016 and determined the language cited in the deficiency was appropriate and no revisions to the Plan were necessary. The list of chemicals used by Environmental Services was presented to the Infection Control	04/08/2016

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	<p>Procedure Documents, Files, and Manuals (reviewed 8-15) indicated the following: "Obtain committee approval for departmental specific procedures that relate to Infection Control and (Environmental) Safety from the respective committees..."</p> <p>2. The policy/procedure Infection Prevention Control Plan (approved 3-15) indicated the following: "The (IC) Committee will review and assist other departments in revising the infection prevention and control portions of their policies and procedures at least every three years. This will include general requirements for asepsis, sanitation, traffic control, isolation, etc."</p> <p>3. Review of the Environmental Services Chemical List failed to indicate a date of origin or date of review, the facility name and a responsible person or policy owner, or documentation of approval and/or review by the IC committee or an IC committee representative.</p> <p>4. During an interview on 2-24-16 at 1240 hours, the Safety, Accreditation and Compliance officer, staff A2, confirmed that the Environmental Services Chemical List failed to indicate documentation of review or approval by the IC committee or IC representative</p>		<p>Committee and approved by said committee on March 21,2016. The Environmental Services Chemical list document was updated to include the date of origin, facility name, responsible person and date of Infection Control Committee approval on April 8, 2016. The Director of Environmental Services, who sits on the Infection Control Committee will bring the chemical list to the committee for review annually and anytime there is a change of product requested. The list will be updated annually to document this review and approval.</p>	

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S 0596 Bldg. 00	<p>and no other documentation was available.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and interview, the infection control (IC) committee lacked documentation indicating IC program oversight and review of surgical services policy/procedures for cleaning, disinfecting and sterilizing surgical instruments at the facility.</p> <p>Findings include:</p> <p>1. The policy/procedure titled Policies & Procedure Documents, Files, and Manuals (reviewed 8-15) indicated the following: "Obtain committee approval</p>	S 0596	The Executive Director of Surgical Services holds responsibility for the corrective actions and for ensuring ongoing compliance for those items cited under this tag. The Coordinator of Epidemiology reviewed the Infection Control Plan on April 1, 2016 and determined the language cited in the deficiency was appropriate and no revisions to the Plan were necessary. The "Instrument Reprocessing" policy was reviewed by Infection Prevention and Director of Surgery on April 12, 2016 and revised in accordance with AORN, CDC and ANSI/AAMI standards. The required	05/09/2016

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	<p>for departmental specific procedures that relate to Infection Control and (Environmental) Safety from the respective committees..."</p> <p>2. The policy/procedure Infection Prevention Control Plan (approved 3-15) indicated the following: "The (IC) Committee will review and assist other departments in revising the infection prevention and control portions of their policies and procedures at least every three years. This will include general requirements for asepsis, sanitation, traffic control, isolation, etc."</p> <p>3. Review of the policy/procedure Instrument Reprocessing (reviewed 2-14) failed to indicate the IC Committee was one of the Required Approvals in the header box at the top of the document and the Document History at the bottom of page 2 failed to indicate a date when the IC committee had approved or reviewed the policy/procedure.</p> <p>4. During an interview on 2-24-16 at 1240 hours, the Safety, Accreditation and Compliance officer, staff A2, confirmed that the policy/procedure failed to indicate IC committee approval or review with origination in 2009 or with the 2014 review and no other documentation was available.</p>		<p>approvals were updated to include Infection Control Committee and the document history box at the bottom of the policy was updated to reflect Infection Prevention oversight. The revised policy was distributed to the members of the Infection Control Committee and Hospital Leadership for approval on April 13, 2016. Infection Prevention and Surgical Services leadership will review all surgical services department policies to ensure all relevant policies include documentation of Infection Prevention input and Infection Control Committee approval if necessary. Those identified as needing Infection Control Committee approval will be brought before the committee for approval at their May 9, 2016 meeting. Ongoing compliance will be monitored via the policy review process which occurs at a minimum of every three years.</p>				

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S 0602 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL</p> <p>410 IAC 15-1.5-2(f)(3)(D)(vi)</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>(vi) An isolation system. Based on document review, observation and interview, the infection control (IC) committee failed to ensure an effective cleaning product was immediately available for use with isolation patients diagnosed with the communicable disease Clostridium difficile (C diff) at the facility.</p> <p>Findings include:</p> <p>1. The Infection Control and Hospital Epidemiology publication titled 'Strategies to Prevent Clostridium difficile Infections in Acute Care Hospitals: 2014 Update' indicated the following: "C. difficile now rivals methicillin-resistant Staphylococcus</p>	S 0602	The Infection Prevention Nurse and the Coordinator of Epidemiology hold joint responsibility for the corrective actions and ongoing compliance related to those items cited under this tag. The Infection Prevention Nurse and Coordinator of Epidemiology reviewed the publication referenced in finding #1 'Strategies to Prevent Clostridium difficile Infections in Acute Care Hospitals: 2014 Update'. The specific statement referenced goes on to state "(EPA)-approved sporicidal product in an outbreak or hyperendemic setting". In addition, the APIC Elimination Guide <i>Guide to preventing clostridium difficile infections</i> 2013 indicates on pages 50-51	04/15/2016

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	<p>aureus (MRSA) as the most common organism to cause healthcare-associated infections (HAIs) in the United States... [and]... Perform environmental decontamination of rooms of patients with Clostridium difficile using sodium hypochlorite (household bleach) diluted 1:10 with water or an Environmental Protection Agency (EPA)-approved sporicidal product..."</p> <p>2. The policy/procedure Isolation Precautions (approved 3-15) failed to identify Clostridium difficile (C.diff) as an epidemiologically important organism with special requirements for effective environmental decontamination and hand hygiene.</p> <p>3. The policy/procedure Clostridium Difficile Protocol (approved 3-15) indicated the following: "All equipment will be disinfected with hospital approved disinfectant when removed from patient's room." The policy/procedure lacked if a disinfectant product other than an approved quaternary ammonium disinfectant was required for effective decontamination of environmental surfaces and equipment associated with a patient diagnosed with C. difficile.</p> <p>4. During a tour of the 7th floor medical</p>		<p>"the environment of all patients with CDI do not require cleaning with a hypochlorite solution...in non outbreak settings, continued use of the cleaner routinely used may be acceptable". Outbreaks have not been identified in the facility. In response to an increase of c diff prevalence (both community onset and healthcare onset), Infection Prevention recommended and the Infection Control Committee approved at their January, 2016 meeting the addition of bleach wipes for clinical staff use over and above the previously existing process of Environmental Services using bleach for daily and terminal room cleaning for patients with c diff. This topic was discussed at length with the surveyor. The surveyor was provided documentation of the following:</p> <ul style="list-style-type: none"> ·Infection Prevention presentation on special precautions for c diff rooms used during training of Environmental Services staff in the Fall of 2014 and 2015. ·Sign in sheets containing names of EVS staff who attended each training session ·Standard work document outlining the specific cleaning process for c diff room ·Minutes from the January 11, 2016 Infection Control Committee Meeting showing approval of use of bleach wipes for clinical staff use <p>The surveyor did not take the</p>	

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	<p>surgical (MS) unit on 2-24-16 at 1203 hours, in the presence of the unit manager, staff A18, and the Executive Director, staff A17, the patient care hallway was observed with an isolation cart outside of room 723 together with a sign indicating that Enteric Isolation Precautions were in effect. A container of quaternary ammonium-based, purple-topped PDI Super Sani Wipes was observed on top of the isolation cart and no bleach-based disinfectants or EPA-approved sporicidal products were available for use if needed.</p> <p>5. During an interview on 3-15-16 at 1512 hours, the unit manager, staff A18, and the Executive Director, staff A17, confirmed the PDI Super Sani Wipes were not effective for disinfection when enteric isolation precautions were in effect and confirmed that no other disinfecting products were present and available for use by staff if needed.</p>		<p>opportunity to observe the cleaning of a c diff room nor did the surveyor interview an Environmental Services Staff member as part of his evaluation of the organizations compliance with the stated practice Following approval of the use of bleach wipes for clinical staff use, Infection Prevention immediately began the lengthy process required to procure the new bleach wipe product. A product and vendor was selected, unit par levels determined, orders were placed and clinical staff education had begun prior to the survey. The finding #4 is accurate in that at the time of survey bleach wipes were not available on a c diff patient's isolation cart for clinical use. The wipes were not on the cart because the new product had not been received by the organization and therefore had not been distributed to the units for use by clinical staff. The bleach wipes have since been received and were placed into use in March, 2016. The Isolation Precautions policy cited in finding #2 was revised to include c diff in the Contact Precautions section identifying it as an epidemiologically important organism. The policy was also revised to include a reference to the separate Clostridium Difficile Protocol policy for guidance on special requirements for effective environmental decontamination and hand hygiene. The policy</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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(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
			<p>was revised on April 4, 2016 and approved by the Infection Control Committee and Hospital Leadership. The finding cited in #3 in regard to the Clostridium Difficile Protocol policy is accurate as at the time of survey it lacked direction for use of a hospital approved sporicidal product for decontamination of environmental surfaces and equipment associated with patients diagnosed with c diff. The policy had not been revised because the process for use of bleach wipes approved by the Infection Control Committee in January, 2016 had not been implemented due to the time required to procure and distribute the bleach wipes. The policy was revised on April 5, 2016 to include the use of bleach wipes (a sporicidal product) and approved by the Infection Control Committee and Hospital Leadership. Infection Prevention will ensure appropriate disinfectants are used throughout the organization by their ongoing review of scientific literature and continuing education opportunities. In addition, Environmental Services will monitor staff performance by visual inspection and ATP monitoring which is a process that detects if there are any living cells on a surface after disinfection. The Director of Environmental Services shall report all deficiencies identified in</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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S 0608 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL</p> <p>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 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 document review and interview, the infection control (IC) committee lacked documentation indicating IC program oversight and review for surgical attire worn in the restricted access areas at the facility.</p> <p>Findings include:</p> <p>1. The policy/procedure titled Policies & Procedure Documents, Files, and Manuals (reviewed 8-15) indicated the following: "Obtain committee approval for departmental specific procedures that relate to Infection Control and</p>	S 0608	<p>their monitoring process to Infection Prevention.</p> <p>The Executive Director of Surgical Services holds responsibility for the corrective actions and ongoing compliance related to the items cited under this tag. The Coordinator of Epidemiology and the Director of Surgery reviewed the Surgical Attire policy on April 12, 2016 and made revisions to include the requirement for Infection Control Committee approval. The policy was distributed to the Infection Control Committee and Hospital Leadership for approval on April 13, 2016. The Director of Surgery and Infection Prevention developed an action plan to review all remaining Surgical</p>	05/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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(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
	<p>(Environmental) Safety from the respective committees..."</p> <p>2. The policy/procedure Infection Prevention Control Plan (approved 3-15) indicated the following: "The (IC) Committee will review and assist other departments in revising the infection prevention and control portions of their policies and procedures at least every three years. This will include general requirements for asepsis, sanitation, traffic control, isolation, etc."</p> <p>3. Review of the policy/procedure Surgical Attire (reviewed 6-15) indicated the following: "Required Approvals: IC Committee" in the header box at the top of the document and the Document History at the bottom of page 2 failed to indicate a date when the IC committee had approved or reviewed the policy/procedure.</p> <p>4. During an interview on 2-24-16 at 1240 hours, the Safety, Accreditation and Compliance officer, staff A2, confirmed that the policy/procedure failed to indicate IC committee approval or review with origination in 2009 or with the 2015 review and no other documentation was available.</p>		<p>Services policies to ensure those which are applicable have received Infection Prevention oversight and Infection Control Committee approval if necessary. All policies identified as needing Infection Control Committee approval will be presented to the committee at their next meeting to be held on May 9, 2016. Ongoing compliance will be monitored utilizing the process by which all policies are reviewed by the appropriate stakeholders and revisions approved at a minimum of every three years.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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(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 0612 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL</p> <p>410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on observation, document review and staff interview, the infection control committee failed to ensure clean rags and mop heads were stored in a clean and sanitary environment in the in-house Laundry Department and failed to develop and maintain a laundry management plan/program for personnel involved with soiled linen handling at the facility.</p> <p>Findings included:</p> <p>1. During tour of the basement at 2:30 PM on 2/23/2016, in the in-house Laundry Department, the environmental staff were observed washing and drying mops and rags in an industrial washer and dryer. The dry mops and rags were</p>	S 0612	The Director of Environmental Services holds responsibility for corrective actions and ongoing compliance related to the items cited under this tag. The Director of Environmental Services, in collaboration with Infection Prevention, created new policies "Handling Soiled Linen" and "Linen Management & Distribution" to define appropriate processes related to the specific items cited in the survey. These policies were developed on April 8, 2016. The "Handling Soiled Linen" policy addresses such items as keeping separation from clean linen, containment strategies, cart storage/staging location requirements, PPE requirements and hand hygiene. The "Storage Management and Distribution of Linen" policy	04/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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(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
	<p>observed in large uncovered transport carts. The rags and mops are used in patient rooms and other patient care areas. The Laundry Department had stored assorted supplies: boxes of paper towels, chemicals, equipment, etc. The ceiling surface and piping that ran along the ceiling were observed with an accumulation of dirt and other debris on them. The uncovered containers of clean rags and mop heads were observed under the dirty ceiling. The shelving units and the floor surface where the clean uncovered rags and mop heads were, were observed to be heavily soiled with an accumulation of soil residue.</p> <p>2. In interview at 1:15 PM on 2/24/2016, staff #11 (Environmental Service Supervisor) confirmed all the above and no other documentation was provided prior to exit.</p> <p>3. The American Institute of Architects (AIA) Guidelines for Design and Construction of Hospitals and Healthcare Facilities Chapter 7 (2001) indicated the following: "7.23 Linen Services... Each facility shall have provisions for storing and processing of clean and soiled linen for appropriate patient care... A separate room for receiving and holding soiled linen until ready for pickup or processing... Cart storage area(s) for separate parking of clean-and soiled-linen</p>		<p>outlines clean and soiled linen storage/transport requirements, necessity to keep clean linen covered and storage areas routinely cleaned. Both policies were vetted for approval through both the Infection Control Committee and Hospital Leadership. These policies provide guidance to staff related to the findings cited under this tag. Additionally, the follow actions were taken to correct each specific finding: Finding #1 Ceiling surface and piping in Laundry Department was cleaned with a microfiber tool and disinfectant on April 8, 2016.</p> <ul style="list-style-type: none"> ·New vinyl covers were placed on the carts containing the clean rags and mop heads on April 8, 2016. ·The shelving units were bleached, wiped and steamed on April 12, 2016. ·The floors were cleaned on April 12, 2016. <p>Finding #2</p> <ul style="list-style-type: none"> ·The organization is in agreement with the statement as written. <p>Finding #3</p> <ul style="list-style-type: none"> ·The organization reviewed the AIA guidelines and is in agreement with the sections stipulated in the finding. <p>Finding #4</p> <ul style="list-style-type: none"> ·The Linen Utilization policy was reviewed and determined it was appropriate based on the scope of the policy. ·A new policy (as described 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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(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
	<p>carts out of traffic... Handwashing stations in each area where unbagged, soiled linen is handled."</p> <p>4. The policy/procedure Linen Utilization (approved 1-16) indicated the following: "Handling of soiled linen... All soiled linen should be placed in a linen hamper bag... Place filled/tied bag down chute or into soiled utility room for collection." The policy/procedure lacked what linen handling was to occur after the bag of soiled linen was placed in the linen chute or soiled utility room.</p> <p>5. On 2-23-16 at 1630 hours, the Safety, Accreditation and Compliance officer, staff A2, was requested to provide additional documentation indicating the process for linen handling from arrival by laundry chute to the basement soiled linen room or from a unit-based soiled utility room until truck transport to an offsite laundry provider and none was provided prior to exit.</p> <p>6. During a tour of the basement laundry chute receiving rooms on 2-14-16 at 1210 hours, in the presence of the Executive Director, staff A5, and the Executive Director, staff A17, the soiled laundry room identified as 73-0308 was observed with 3 open soiled linen bags among 20+ closed linen bags. No source of personal</p>		<p>above) "Handling Soiled Linen" was created to define the process related to handling of soiled linen after it is placed in the chute or soiled utility room.</p> <p>Finding #5 ·Organization is in agreement with statement as written. New policies were created as stated above.</p> <p>Finding #6 ·EVS leadership inspected each laundry chute receiving room and other areas where soiled linen is handled to ensure appropriate PPE and handwashing ability was available. Items were re-stocked as needed.</p> <p>Finding #7 ·Organization is in agreement with statement as written. The Director of Environmental Services will ensure ongoing compliance by: · Supervisors will conduct daily audits for a 30 day period ending May 13, 2016 to verify clean rags and mops are covered, appropriate use of new staging areas for clean and dirty linen and stocking of PPE, soap and hand sanitizer. Audit result will be posted in the department. Audit will continue for another 30 day period if results are below 95%. · Regular monthly cleaning of the ceiling and floors has been added to the "Float Route" assignment task list. Supervisors will conduct monthly inspections to ensure compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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(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 0722 Bldg. 00	<p>protective equipment or means of hand hygiene was observed inside the soiled linen room or immediately outside.</p> <p>7. During an interview on 2-24-16 at 1310 hours, the Safety, Accreditation and Compliance officer, staff A2, confirmed no additional policies, guidelines or other documentation was available to indicate the soiled linen handling requirements and/or process for handling soiled laundry from the chute room or soiled utility until transport by a commercial laundry vehicle to an off-site laundry facility.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(5)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(5) Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record if allowed by the hospital policies. Based on document review and interview, the facility failed to ensure the inclusion of reports in the medical record in accordance with facility policy and procedure for 5 of 5 (9, 17, 18, 19 and 20) patient medical records reviewed</p>	S 0722	The Director of Security/Chief of Police holds responsibility for the corrective actions and ongoing compliance related to this deficiency. Immediately following the completion of the survey, the Safety Coordinator and the Director of Security/Chief of	04/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2016	
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601			
(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			
	<p>who expired.</p> <p>Findings:</p> <p>1. Policy titled, Death of Patient, revised/reapproved on 11/15 indicated on pg. 3, point 37, "Security will forward the yellow copy of the Post Mortem Care Record and the Provisional Form to Medical Records to be placed in the patient's chart."</p> <p>2. Review of patient medical records on 2/22/16 and 2/23/16 at 1506 and 1400 hours, respectively, confirmed patient:</p> <p>A. 9, expired on 2/2/15 and lacked documentation of the Provisional Notification of Death - Burial Transit Permit in the medical record.</p> <p>B. 17, expired on 2/15/15 and lacked documentation of the Provisional Notification of Death - Burial Transit Permit in the medical record.</p> <p>C. 18, expired on 1/26/16 and lacked documentation of the Provisional Notification of Death - Burial Transit Permit in the medical record.</p> <p>D. 19, expired on 9/22/15 and lacked documentation of the Provisional Notification of Death - Burial Transit Permit in the medical record.</p> <p>E. 20, expired on 4/30/15 and lacked documentation of the Provisional Notification of Death - Burial Transit</p>		<p>Police investigated the current process related to the Provisional Notification of Death form. It was determined that the responsibility for the form had been transferred to Security from the Registration Department in 2015. The need to distribute the completed form to Medical Records for inclusion in the patient's chart had not been included in the transfer of responsibilities communication. Security had the understanding this form was to be maintained in the department files indefinitely.</p> <p>On April 11, 2016 a team including representation from Medical Records, Security, Nursing Professional Practice & Research Council, Nursing Administration and Safety reviewed the policy titled "Death of Patient". This policy includes direction for staff in the event of a patient death including the specific steps related to the need for the Provisional Notification of Death – Burial Transit Permit to be placed in the patient's medical record. The steps outlined in the policy were compared with current practice. Several revisions were made to the policy to more clearly define the steps necessary to ensure appropriate distribution of this form to Medical Records. The revised policy received the necessary approvals from Nursing Professional Practice & Research Council and Hospital Leadership on April 13, 2016. Nursing, Security and Medical</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601		
(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 0744 Bldg. 00	<p>Permit in the medical record.</p> <p>3. Staff N14 (Vice President of Operations) was interviewed on 2/25/16 at approximately 1000 hours and confirmed the above-mentioned patients lacked a copy of the Provisional Notification of Death - Burial Transit Permit in the medical record as required per facility policy and procedure.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on document review and interview, the facility failed to ensure all entries in the medical record are legible in accordance with facility policy and procedure for 3 of 3 (5, 6 and 7) patient medical records reviewed who underwent a surgical procedure.</p>	S 0744	<p>Records staff were educated on the minor policy revisions April 14, 2016. The Security Secretary retrieved all of the Provisional Notification of Death – Burial Transit Permit documents previously maintained in the Security files and delivered same to Medical Records on April 4, 2016. Medical Records completed the scanning of all Provisional forms into the appropriate medical records (including those which were found to be deficient at the time of survey) on April 15, 2016. The Director of Security/Chief of Police will ensure ongoing compliance by monitoring the Security paperwork distribution process for each event of a deceased patient being released to funeral homes.</p> <p>All of the surgical areas including anesthesia will move to electronic documentation in the third quarter of 2016. Prior to that time all anesthesiologists have been educated regarding the importance of legibility. In addition we have asked that they print whenever possible to improve the likelihood of readability. The</p>	04/12/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2016	
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601			
(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			
	<p>Findings:</p> <p>1. Policy titled, Documentation, revised/reapproved on 1/14 indicated on pg. 2, under Principles section, point 12, and Guidelines for Charting in the Written Record, point 4, "Documentation needs to describe the problem or symptom and status at the time treatment is complete...Entries in the record are to be permanent and legible."</p> <p>2. Review of patient medical records on 2/22/16 and 2/23/16 at 1506 and 1400 hours, respectively, confirmed patient:</p> <p>A. 5, had a cesarean section on 2/13/16 and the Anesthesia Graphic Record and Post-Operative Anesthesia Notes are not legible.</p> <p>B. 6, had an aortic valve replacement and intraoperative transesophageal echocardiogram on 12/11/15 and the Anesthesia Graphic Record and Post-Operative Anesthesia Notes are not legible.</p> <p>C. 7, had a right total hip arthroplasty on 12/14/15 and the Anesthesia Graphic Record and Post-Operative Anesthesia Notes are not legible.</p> <p>3. Staff N14 (Vice President of Operations) was interviewed on 2/25/16 at approximately 1000 hours, and confirmed the Anesthesia Graphic</p>		<p>entire medical staff has in its annual education update a portion referring to legibility and accurate documentation. This education document was presented to MEC April 11, 2016 and was communicated to the entire medical staff on April 12, 2016. The VPMA/Chief Safety Officer is responsible for the above corrective actions and ongoing compliance. The VPMA/Chief Safety Officer will conduct a monthly audit of 10 charts per week to ensure entries on the anesthesia graphic records and post anesthesia assessments are legible. This audit will continue until data shows sustained compliance for a three month period or until the anesthesia documentation is converted to the electronic process.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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(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 0952 Bldg. 00	<p>Record and Post-Operative Anesthesia Notes are not legible for the above-mentioned patients as required per facility policy and procedure.</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 document review and staff interview, the facility failed to ensure 5 of 10 (L1, L2, L3, L7 and L10) blood transfusion records reviewed and 4 of 4 (10, 11, 12 and 13) intravenous medication medical records reviewed were administered in accordance with approved medical staff policies and procedures.</p> <p>Findings included:</p> <p>1. Policy/procedure titled: "Blood Transfusion, Including Blood Components (BB-NUR-080)," last</p>	S 0952	The Vice President of Nursing Services holds responsibility for corrective actions and ongoing compliance related to items cited under this tag. In regard to Findings #1-3: The Blood Bank Manager and Nursing Professional Practice & Research Council reviewed the Policy "Blood Transfusion, Including Blood Components". The section of the policy referenced in Finding #1 ... "Prior to obtaining first unit of blood to be administered...." Was determined to be too restrictive and was therefore removed and replaced with language identifying the elements to be included in a baseline	04/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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	<p>reviewed on "4/18/2013," read: "...Prior to obtaining first unit of blood to be administered in the series ordered by physician...an initial set of vital signs shall be obtained as pre-transfusion baseline vitals..." and "...Begin infusion of blood or blood component immediately, but within 30 minutes of leaving Blood Bank..."</p> <p>2. Review of patient records indicated the following:</p> <p>a. Patient L1 received a blood transfusion on 12-3-2015. The unit of blood was released from the blood bank at "1045" and the transfusion was initiated at "1125," 40 minutes after the blood was released from the blood bank.</p> <p>b. Patient L2 received a blood transfusion on 12-15-2015. The first unit in the series was released from the blood bank at "1339" and pre-transfusion vital signs were taken at "1400," 21 minutes after the blood was obtained from the blood bank.</p> <p>c. Patient L3 received a blood transfusion on 11-18-2015. The first unit in the series was released from the blood bank at "1115" and pre-transfusion vital signs were taken at "1131," 16 minutes after the blood was obtained from the blood bank.</p> <p>d. Patient L7 received a blood transfusion on 11-12-2015. The first unit</p>		<p>assessment of the recipient of the blood product. Another section of the policy referenced in Finding #1 "...Begin infusion of blood or blood component immediately, but within 30 minutes of leaving Blood Bank..." was reviewed. This requirement was determined to be appropriate; however this section of the policy was revised to improve clarity to the staff administering blood products. Education on the findings received and the policy revisions was communicated at Safety Huddle and via email communication to staff on Friday, April 15, 2016. Additionally, the Nursing Professional Development council communicated the education to all the unit educators via email. Unit educators will continue to provide unit staff education through the end of April, 2016 and ongoing as needed if outliers are identified during the monthly audit process. The Vice President of Nursing and the Blood Bank Manger will ensure ongoing compliance by adding an element to the existing blood product administration monthly audit tool to capture the time the blood product was picked up from the blood bank and comparing this time to the time the transfusion was initiated to ensure it is in compliance with the 30 minute requirement. Results of the monthly audit are reported to the Transfusion Committee. In</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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	<p>in the series was released from the blood bank at "1028" and pre-transfusion vital signs were taken at "1045," 17 minutes after the blood was obtained from the blood bank.</p> <p>e. Patient L10 received a blood transfusion on 12-4-2015. The first unit in the series was released from the blood bank at "1053" and pre-transfusion vital signs were taken at "1110," 17 minutes after the blood was obtained from the blood bank.</p> <p>3. In interview on 2-25-2016 at 10:50 AM, Staff Member #L2 acknowledged the following:</p> <p>a. The blood transfusion for Patient L1 was started more than 30 minutes after the blood was released from the blood bank.</p> <p>b. Pre-transfusion vital signs were taken after the blood was obtained from the blood bank for patients L2, L3, L7, and L10.</p> <p>4. Policy titled, Medication, Safe Administration, revised/reapproved on 8/15 indicated on pg. 3, under Right Documentation section, point b, "Documentation of medication administration will be accurate with regard to date, time, and all other considerations as required by the Medical Records Department...Electronic MAR (Medication Administration Record):</p>		<p>regard to Findings #4-7: The Vice President of Nursing and members from the Nursing Professional Practice & Research Council reviewed the policy and Skills & Techniques documents referenced in the findings. The "Medication, Safe Administration" policy was determined to be appropriate as written as it provides clear direction on the elements to be documented in the patient's chart. Medical Records requirements do not stipulate the date and time an infusion is completed be documented in the patient's chart. The "Clinical Nursing Skills & Techniques" document referenced is not a policy but rather a resource document created by an outside entity. This document was reviewed and determined to be in conflict with the "Medication, Safe Administration" policy. This document did contain direction to document the date and time the infusion was completed, which along with several other pieces of the document were not consistent with the organizations policy. Therefore, this resource document was removed from use and a new clinical resource document was created which is in alignment with the policy. The documentation in the patient records reviewed at survey were in alignment with the Medication, Safe Administration policy, therefore no changes to the</p>	

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	<p>Medications and infusions are documented on the eMAR utilizing bar code scanning in most cases."</p> <p>5. Review of Clinical Nursing Skills & Techniques: Intravenous (IV) Therapy Initiation, revised/reapproved on 6/15 indicated on pg: A. 3, under Procedure section, point 4, "Ensure the six rights of medication safety...dose, time..." B. 10, under Monitoring and Care section, point 2, "Check that correct amount of IV solution has infused by comparing time tape on IV container or by checking IV infusion record." C. 11, under Expected Outcomes and Documentation sections, bulleted points, "IV therapy correctly administered according to the six rights of medication safety...IV line patent, with infusion delivered at ordered rate...Amount infused..."</p> <p>6. Review of patient medical records on 2/22/16 and 2/23/16 at 1506 and 1400 hours, respectively, confirmed patient: A. 10, had an intravenous medication start date of 12/14/15 at 1530 hours, consisting of cyclophosphamide 2220 mg, mesna 444 mg and sodium chloride 09% 250 ml to be infused over 1 hour per physician order. Lacked the date and time the infusion was completed.</p>		<p>charting capabilities in the electronic medical record system were necessary. Nursing staff were educated on the removal of the original resource document and the presence of the new resource document at the Safety Huddle and via email communication to staff on April 15, 2016 as well as ongoing education received from their unit nursing educators.</p>	

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S 1022	<p>B. 11, had an intravenous medication start date of 2/23/16 at 1000 hours, consisting of ampicillin 2 gm to be infused over 30 minutes per physician order. Lacked the date and time the infusion was completed.</p> <p>C. 12, had an intravenous medication start date of 2/19/16 at 1623 hours, consisting of zosyn 3.375 gm and sodium chloride 09% 100 ml to be infused over 4 hours per physician order. Lacked the date and time the infusion was completed.</p> <p>D. 13, had an intravenous medication start date of 2/21/16 at 2038 hours, consisting of unasyn 1.5 gm to be infused over 30 minutes per physician order. Lacked the date and time the infusion was completed.</p> <p>7. Staff N23 (Nurse Educator) was interviewed on 2/23/16 at approximately 1450 hours, and confirmed the patient Electronic Medical Record does not have a place built into it for entering the stop time of IV medication administration. Therefore, nursing staff cannot determine if physician orders were followed related to the amount infused over the time period it was ordered to be infused.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES</p>				

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Bldg. 00	<p>410 IAC 15-1.5-7 (d)(2)(B)</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>(B) Appropriate storage conditions. Based on document review, observation and interview, the facility failed to ensure appropriate storage conditions for medications according to facility policy and procedure for 1 of 8 (Mother/Baby 4th Floor) areas toured.</p> <p>Findings:</p> <p>1. Policy titled, Automated Medication Dispensing Machine - ADM, revised/reapproved on 10/14 indicated on pg. 2, under point 8.d., "Patients will be assigned a 'patient specific bin' based on room number for the purpose of storing medications not routinely stocked within the ADM...Nursing will remove medications from the patient specific bins and place them in the pharmacy return bin upon discharge."</p> <p>2. While on tour of facility on 2/23/16 at approximately 1000 hours, accompanied by staff N13 (Vice President of Medical</p>	S 1022	<p>The Director of Mother Baby holds responsibility for corrective actions and ensuring ongoing compliance for this deficiency. The patient specific medications found were removed and returned to Pharmacy at the time of survey. The Director of Mother Baby provided an inservice on February 23, 2016 to the Mother Baby staff on the process and importance of removing patient specific medications from storage at the time the patient is discharged. The education was also included in the department weekly education newsletter distributed to all staff on March 5, 2016. The Director of Mother Baby will ensure ongoing compliance by monitoring the results of the monthly unit inspections for expired supplies and medications. Any potential deficiencies identified on the checklist will be immediately addressed with the staff.</p>	05/05/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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S 1024 Bldg. 00	<p>Affairs), staff N14 (Vice President of Operations) and staff N15 (Manager of Mother/Baby 4th Floor Unit), two open bottles of injectable insulin of Humalog and Humulin N were observed in the Medication Room fridge of the Mother/Baby 4th Floor Unit. These medications were labeled for use by a patient who was discharged on 1/16/16.</p> <p>3. Staff N15 (Manager of Mother/Baby 4th Floor) was interviewed on 2/23/16 at approximately 1027 hours, and confirmed the process for removing medications of patients who have been discharged is to place the medications in the pharmacy return bin. This was not done for the above-mentioned patient as required by facility policy and procedure.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</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>(C) Detection and quarantine of</p>			

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	<p>outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on document review, observation and interview, the facility failed to ensure detection and quarantine of outdated medications according to facility policy and procedure for 2 of 8 (Mother/Baby 4th Floor and Child Birthing Unit/Special Birthing Unit [CBU/SBU]) areas toured.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Policy titled, Medication Purchasing and Storage in the Pharmacy, revised/reapproved on 5/15 indicated on pg. 2, under Receipt of Medications section, point e, "When medications are placed into active stock, expiration dates should be reviewed and stock rotated so that products with the earliest expiration dates will be dispensed first." 2. Policy titled, Code Cart, AED, and Defibrillator Monitor Checks, revised/reapproved on 9/14 indicated on pg. 2, under Monitoring section, "Department leadership shall establish a process to evaluate compliance with code cart, AED, and defibrillator checks and shall take appropriate action to correct all instances of non-compliance." 	S 1024	<p>The Director of Mother Baby/Child Birth Unit holds responsibility for the corrective action and ongoing compliance with the deficiencies related to the expired medications found in the medication refrigerator located on the Mother Baby unit. In January, 2016 the Director of the Mother Baby/Child Birth Unit implemented a process whereby the charge nurses utilize a checklist to conduct monthly inspections for the presence of expired supplies and medications. The checklist includes specific locations within the department(s) where supplies and/or medications are stored. When the expired medications were discovered in the medication refrigerator at the time of survey, the check list was reviewed and it was determined the medication refrigerator was not included as a location on the checklist. The medication refrigerator was added to the checklist in March, 2016. The charge nurses were educated on the addition of the medication refrigerator location on the checklist on March 24, 2016. The Director of Mother Baby/Child Birth Units will ensure ongoing compliance by reviewing the monthly inspection checklist. Any</p>	04/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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	<p>3. While on tour of facility on 2/23/16 at approximately 1000 hours, accompanied by staff N13 (Vice President of Medical Affairs), staff N14 (Vice President of Operations) and staff N15 (Manager of Mother/Baby 4th Floor Unit), the following was observed on the:</p> <p>A. Mother/Baby 4th Floor in the Medication Room fridge:</p> <p>(1). Epinepherine topical 1:100,000 solution, lot #20151028-F, open vial in fridge with beyond use date (BUD) 11/27/15.</p> <p>(2). two chlamydia and mycoplasma transport medium tubes by Remel Corporation, lot #529306, expired 1/13/16.</p> <p>B. Mother/Baby 4th Floor in the Adult-Peds Code Box in the bottom drawer of the crash cart just outside the door to the nursery:</p> <p>(1). had a label on the outside of the Pulmonary Peds/Adult Airway Box with a date of 10/8/no year.</p> <p>(2). Pulmonary Peds/Adult Airway Box Check List located inside the box had a date of 10/8/15 of the last time the contents of the box were checked.</p> <p>(3). an EtCO2 expired on 1/16.</p> <p>C. CBU/SBU in the anesthesia workroom:</p> <p>(1). had a label on the outside of the Pulmonary Peds/Adult Airway Box with a date of 12/12/13.</p>		<p>potential deficiencies identified on the checklist will be immediately addressed with the staff. The Manager of Pulmonary Services holds responsibility for the corrective actions and ongoing compliance related to ensuring the supplies stored within the Airway boxes on the code carts are not expired and ready for use. Pulmonary Services maintains a list of the location of all Airway Boxes and it is their practice to check each box monthly. An investigation was conducted to identify barriers to the success of this process. The investigation identified that the Airway box found in the CBU Anesthesia workroom had been used at some time and was not placed back on the code cart. When Pulmonary staff attempted to inspect the box it was not found on the code cart so another box was provided. Upon survey the original Airway box was discovered in a separate location from the code cart. The Pulmonary Services Respiratory Council determined process improvements to include development of an Airway box inventory identifying expiration dates for supplies in each box. The boxes with the most current expiration dates are now the priority in the monthly inspection process. Additional steps are also to be taken to locate Airway boxes when it is not found in it's intended location on the code</p>	

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S 1124	<p>(2). Pulmonary Peds/Adult Airway Box Check List located inside the box had a date of 12/12/13 of the last time the contents of the box were checked.</p> <p>(3). one tube of lidocaine hydrochloride jelly, lot #616404, expired on 1/16.</p> <p>4. Staff N15 (Manager of Mother/Baby 4th Floor) was interviewed on 2/23/16 at approximately 1027 hours, and confirmed medication storage areas, including fridges are to be checked monthly for outdates and expired medications returned to pharmacy. This was not done for the above-mentioned medications as required by facility policy and procedure.</p> <p>5. Staff N17 (Registered Respiratory Therapist & Clinical Specialist) was interviewed on 2/23/16 at approximately 1055 hours, and confirmed Pulmonary Peds/Adult Airway Boxes are to be checked monthly for outdates and expired medications returned to pharmacy. This was not done for the above-mentioned boxes as required by facility policy and procedure.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT</p>		<p>cart. Pulmonary Services staff were educated on these process changes April 15, 2016. Ongoing compliance will be monitored by utilizing the existing daily code cart inspection log which includes an indicator to trigger looking for expired supplies.</p>		

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NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601
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Bldg. 00	<p>410 IAC 15-1.5-8 (b)(5)(A)</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>(A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.</p> <p>Based on interview, the hospital failed to ensure there were operation, maintenance and spare parts manuals for 2 blanket warmers and assorted patient care equipment in Pediatric Rehabilitation Clinic off-site.</p> <p>Findings included:</p> <p>1. In interview of staff member #9 (Pediatric Rehabilitation Clinic Supervisor) at 9:20 AM on 2/23/2016, the staff member confirmed that the following patient care equipment does not have operation, maintenance and spare parts manuals: assorted pediatric</p>	S 1124	<p>The Director of Facilities Services holds responsibility for corrective actions and ongoing compliance related to this deficiency. The Manufacturers operating, maintenance and spare parts manual for the Blanket warmers identified was purchased and received on March 1, 2016. The manufacturers operating, maintenance and spare parts manual for the infant high chairs and pediatric snug seats were found in the Pediatric Rehab Department on April 15, 2016. The PVC Wheelchair and the jungle gym were both custom built and therefore no manufacturers manuals are available. Internal inspection</p>	06/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601		
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S 1160 Bldg. 00	snug seats, PVC Wheelchair, assorted infant high chairs and a jungle gym play set. 2. In interview of staff member #1 (Director Quality Management) at 10:15 AM on 2/25/2016, it was confirmed that the two Amsco/Steris Single Compartment Blanket Warmers located at 10, 11 and 12 south patient floors do not have Manufacturer's operational manuals.		protocols were developed for these pieces of equipment on April 13, 2016. The Director of Facilities Services created an action plan whereby all equipment used at the Peds Rehab Department will be assessed to determine if it falls within the parameters of requiring regular preventative maintenance or inspections. The plan includes obtaining manufacturers manuals for qualifying equipment. Due to the large scope of this process the action plan is designed to be completed in manageable phases as follows: Phase I target completion date: May 15, 2016 Identify key stakeholders, schedule a day long Kaizen event, conduct initial planning meeting to define scope of event and final identification of participants. Phase II target completion date: June 15, 2016 Kaizen event completed. All equipment requiring preventative maintenance or inspections and manufacturers manuals identified. Responsibility for PMs assigned. PM schedule created. Manufacturers manuals received and preventative maintenance/inspections completed as required. Plan to ensure ongoing compliance with PM requirements developed and implemented.		
	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)				

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	<p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on observation and interview, the facility failed to regularly service and maintain its equipment in good working order for one tabletop blanket warmer observed on tour.</p> <p>Findings include:</p> <ol style="list-style-type: none"> During a tour of the 11th floor medical unit on 2-22-16 at 1540 hours, in the company of the IC nurse, staff A10, and the unit manager, staff A21, the presence of a large amount of accumulated dust was observed in the heating element area under the plenum of a tabletop blanket warmer, asset tag #0850. On 2-23-16 at 1630 hours, the Safety, Accreditation and Compliance officer, staff A2, was requested to provide a policy/procedure and documentation of preventive maintenance for the indicated blanket warmer and none was received prior to exit. On 2-29-16 at 1633 hours, the Safety, Accreditation and Compliance officer, 	S 1160	<p>The Director of Facilities Services ordered and received the operation, maintenance and spare parts manuals for the blanket warmers on March 1, 2016. All blanket warmers in the facility and off site locations operating under the hospital license were inventoried on March 24, 2016. This inventory list was then compared against the known list in the preventative maintenance electronic system. All previously unidentified blanket warmers were tagged and the assets were added to the electronic system. The existing blanket warmer preventative maintenance protocol was updated to match the manufacturers recommended process and intervals. The blanket warmer on the 11th floor found to have an accumulation of dust was cleaned the first week of March, 2016. The Director of Facilities Services inspected this blanket warmer and those on the 10th and 12th floors on April 13, 2016 and all warmers were found to be free to dust. The Director of Facilities Services will ensure ongoing compliance by monitoring the electronic preventative maintenance system</p>	04/15/2016

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S 1164 Bldg. 00	<p>staff A2, confirmed that no policy/procedure or documentation of preventive maintenance was available.</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 documentation review, observation interview, the hospital failed to enter into equipment inventory or conduct preventive maintenance inspections on 10 patient-care equipment located in the Pediatric Rehabilitation Clinic off-site.</p> <p>Findings include:</p> <p>1. Memorial Hospital of South Bend Medical Equipment Management Plan stated, "Upon receipt of equipment, Material Management will route to Bio-Medical Engineering to be safety checked. If approved, the equipment is entered into inventory and routed to the</p>	S 1164	<p>monthly. Results of all PM activity will be reported to the Operations and Patient Safety Committee monthly.</p> <p>The responsibility for the equipment identified during the tour of the Pediatric Rehabilitation Clinic is shared between the Director of Facilities Services and the Manger of Biomedical Engineering. Responsibility is determined based on the type and use of equipment. On April 13, 2016 and April 14, 2016 Facilities Services inspected the Jungle Gym, wheel chair, snug seats, high chairs and the ceiling mounted swing. All equipment identified to be the responsibility of Facilities Services was tagged and added to the asset inventory. Annual preventative maintenance requirements were entered into the electronic asset inventory system to ensure PMs occur as</p>	04/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150058	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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	<p>end user."</p> <p>2. During the tour of Pediatric Rehabilitation Clinic at 1:00 PM on 2/24/2016, the off-site consisted of multiple patient-care equipment that had no evidence they were inventoried and had preventive maintenance inspection conducted on them.</p> <p>3. Review of the of the hospital's preventive maintenance documentation on patient-care equipment indicated ten (10) patient-care equipment located in the Pediatric Rehabilitation Clinic had not been inventoried or had a preventive maintenance inspection conducted on them: 4 assorted snug seats, jungle gym, PVC wheelchair, large ceiling mounted swing, and 3 assorted high chairs.</p> <p>4. In interview at 1:15 PM on 2/24/2016, staff member #9 (Pediatric Rehabilitation Clinic Supervisor) confirmed all the above and no other documentation was provided prior to exit.</p>		<p>required. Facilities Services staff responsible for this equipment were educated on the additional PM requirements. In March, 2016 Biomedical Engineering toured the department and identified a powered treatment table which was in need of inspection. This item was added to their electronic asset inventory system and is now scheduled for regular preventative maintenance in accordance with the manufacturers recommendations. The Director of Facilities Services and the Manger of Biomedical Engineering will ensure preventative maintenance on the equipment at the Pediatric Rehabilitation Clinic by reviewing their respective electronic PM systems monthly to identify any tasks that were not completed within the required time frame. The results of the reviews will be reported to the Operations & Patient Safety Committee on a monthly basis.</p>	

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S 1172 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation and interview, the environmental services failed to ensure its surgical environment was maintained in a sanitary manner and ensure its patient care areas, including ventilation grilles, were free of dust at the facility.</p> <p>Findings include:</p> <p>1. During a tour of the surgery services on 2-23-16 at 1056 hours, in the company of the infection control (IC) nurse, staff A10, the perioperative services director, staff A12, and the ambulatory care center (ACC) director, staff A13, the presence of a significant amount of accumulated dust was observed on a 12" x 48"</p>	S 1172	The Director of Environmental Services holds responsibility for the corrective actions and ongoing compliance related the the items cited under this tag. On April 13, 2016 the Director of Environmental Services developed a policy related to vent and grille cleaning. The policy provides guidelines to EVS staff regarding the inclusion of vent and grille cleaning as part of their general cleaning duties in their assigned area. Hospital Leadership approved the policy on April 14, 2016 and the Environmental Services staff will be trained during a department meeting on April 16, 2016. All window sills, blanket warmers, smoke detectors, diffusers, and	04/16/2016

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	<p>window sill in the outer hallway adjacent to operating room #6 (OR 6).</p> <p>2. During a tour of the surgery services on 2-23-16 at 1108 hours, in the company of the IC nurse, staff A10, the perioperative director, staff A12, and the ACC director, staff A13, the presence of accumulated dust was observed on the top of a tabletop blanket warmer in the cystoscopy room adjacent to OR #8.</p> <p>3. During a tour of the surgery services on 2-23-16 at 1113 hours, in the company of the IC nurse, staff A10, the perioperative director, staff A12, and the ACC director, staff A13, the presence of accumulated dust was observed on the smoke detector and on the 24" x 24" ceiling diffuser in the cryostat room adjacent to OR #9.</p> <p>4. During a tour of the emergency services on 2-23-16 at 1203 hours, in the company of the IC nurse, staff A10, the ACC director, staff A13, and the central sterile processing (CSP) director, staff A14, the presence of a significant amount of accumulated dust was observed on the 24" x 24" ceiling ventilation grille in the staff hallway outside of the emergency department.</p> <p>5. During a tour of the central sterile</p>		<p>ceiling vent grilles identified in the survey were cleaned between April 8, 2016 and April 13, 2016. The Director of Environmental Services will ensure ongoing compliance by conducting weekly inspections. Any deficiency identified in the inspections will be addressed with those staff members who had been assigned cleaning responsibility over that area.</p>				

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	<p>services on 2-23-16 at 1215 hours, in the company of the IC nurse, staff A10, the ACC director, staff A13, and the CSP director, staff A14, the presence of a significant amount of accumulated dust was observed on three of five 24" x 24" ceiling ventilation grilles located directly over the area where sterilized instrument cassettes and wrapped packs are removed from wall-mounted sterilizers in the clean room.</p> <p>6. During a tour of the intensive care unit (ICU) on 2-23-16 at 1345 hours, in the company of the IC nurse, staff A10, and the ICU director, staff A15, the presence of a significant amount of accumulated dust was observed on the 12" x 24" ceiling ventilation grille in the ICU room 224 and on the 12" x 24" ceiling ventilation grille in the hallway outside room 226.</p> <p>7. On 2-23-16 at 1630 hours, the Safety, Accreditation and Compliance officer, staff A2, was requested to provide a policy/procedure and documentation of periodic ventilator grille cleaning and none was received prior to exit.</p> <p>8. On 2-29-16 at 1633 hours, the Safety, Accreditation and Compliance officer, staff A2, confirmed that no policy/procedure and/or documentation</p>			

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S 1186 Bldg. 00	<p>of periodic ventilator grille cleaning was available.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to ensure 4 of 12 hospital licensed off-site locations conducted the fire drills for 2015.</p> <p>The findings include:</p> <p>1. In review of Memorial Hospital of South Bend Fire Safety Management</p>	S 1186	The four off-site locations that were lacking documentation of fire drills within the last 12 month period are located in leased space therefore the fire protection systems are not owned or operated by the Hospital. While this does not eliminate the need to conduct fire drills, it does make it a bit more challenging. The Director of Facilities Services reached out to the landlords of	04/15/2016

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	<p>Plan, the plan stated, "Fire drills are conducted every 12 months in all freestanding buildings classified as business occupancies (e.g., clinics, offices) in which patient care is provided under Memorial Hospital licensure." The policy was last reviewed March 3, 2015.</p> <p>2. In review of the 2015 fire drill's documentation for off-site locations under Memorial Hospital of South Bend licensure, the four off-site locations that documented evidence of fire drill for 2015 were unavailable: Lighthouse Radiology, Lighthouse Place Physical Therapy, Memorial Hospital South Bend-Mishawaka ROC and Nuclear Medicine.</p> <p>3. In interview at 1:00 PM on 2/25/2016, staff member #2 (Safety & TJC Coordinator) confirmed all the above and no other documentation was provided prior to exit.</p>		<p>the 3 buildings to request documentation of fire drills. On April 14, 2016 the landlord of the building where the Mishawaka ROC space is located provided detailed documentation and evaluation of a fire drill conducted on October 9, 2015. The landlord of the other buildings where Nuclear Medicine, Lighthouse Radiology and Lighthouse Place Physical Therapy are located were unable to provide documentation of fire drills within the last 12 months, however they did have documentation of the testing of the fire systems. Fire drills were conducted in both buildings on April 14, 2016 and the hospital departments located in leased space in these buildings were evaluated on their response. The Chief Safety Officer, who is also responsible for the corrective actions, will ensure fire drills are conducted in all off-site locations at least annually by adding this as an indicator on the performance indicator dashboard reviewed by the Operations & Patient Safety Committee monthly.</p>		