EXETER HOSPITAL
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August 8, 2012

Hi Mike/Pat

Enclosed please find the revised document of our Corrective Action Plan, including all attachments. We incorporated the suggestions Pat and I talked about yesterday. Please disregard all prior documents sent.

Sincerely,

Diane E. White, Director
Quality, Accreditation, PI

RECEIVED
AUG 09 2012
BUREAU OF
HEALTH FACILITIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300023	A. BUILDING _____ B. WING _____	07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXETER HOSPITAL INC	5 ALUMNI DRIVE EXETER, NH 03833

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A 000	INITIAL COMMENTS An investigation survey was conducted with a completion date of 6/7/12 in which case #21610 was investigated with the following deficiencies cited: Condition level at 42 CFR 482.11 A747-Infection Control Standard level at 42 CFR 482.23(c)(1) A405 Administration of Drugs Standard level at 42 CFR 482.42(a) A748 Infection Control Officer(s) Standard level at 42 CFR 482.42 (a)(1) A749 Infection Control Officer Responsibilities In accordance with 42 CFR 488.7(a) a full Medicare survey was completed on 7/13/12 to assess the facility's compliance with all the Medicare Conditions of Participation. The following deficiencies were cited: Condition level at 42 CFR 482.11 A747-Infection Control Standard level at 42 CFR 482.42(a) A748 Infection Control Officer(s) Standard level at 42 CFR 482.41 A701 Maintenance of Physical Plant Standard level at 42 CFR 482.42 (a)(1) A749 Infection Control Officer Responsibilities Standard level deficiency 42 CFR 482.23(c)(1) A405 Administration of Drugs from the Investigation survey on 6/7/12 was found to be back in compliance on 7/13/12 survey.	A 000	The following is Exeter Hospital's response to all deficiencies cited in the CMS survey completed July 13, 2012, including those deficiencies cited in the survey completed June 6, 2012. RECEIVED AUG 09 2012 BUREAU OF HEALTH FACILITIES	
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS	A 405		

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

President 8/3/12

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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A 405	Continued From page 1 Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (1) - All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on interview and reenactment for the administration of medication it was determined that the facility failed to follow proper practice of securing controlled medications from potential unauthorized use until the administration of medication has occurred. Findings include: On interview with Staff D (Nursing) on 6/6/12 it was asked by surveyor to show how a case was set up prior to the patient entering the cath lab. Staff D was asked how the medication for the procedure was set up, and how the medication was drawn up. Staff D showed surveyor the type of syringe used, along with showing that a blunt tip needle was used. Staff D showed how each syringe was marked with a sticker with the name of the controlled medication, and then how to enter the Pyxis machine (medication cart). Staff	A 405	Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (1)-All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical Corrective Action: Summary: The process for securing controlled substances in the Cath Lab has been upgraded to require that all staff RN's in the Cath Lab now place drawn up syringes of controlled substances in a secure drawer located in the Pyxis Machine when medications are not being administered to patients. Process: The process of accessing the Pyxis medications, drawing up the controlled substances, and properly labeling the syringes with the name and concentration of the medication remains the same. On June 12, 2012, the changes that have been implemented for secure storage of controlled substances are as follows: after the RN draws up and labels the medication, he or she logs back into Pyxis to access a designated secured drawer, labeled "Cath Lab – Syringe Storage" by using the refill functionality.	6/12/2012 by VP Acute Care

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A 405	Continued From page 2 D continued to explain that the Pyxis has a finger print scan along with a password. Once entered a single vial would be dispensed, each vial has 2 mg (milligrams) which would be drawn up into the syringe. Once the medications are drawn up Staff D stated that they are placed onto the Pyxis (medication cart) at which time Staff D would walk around the surgical table to get the lead apron on to proceed with the procedure. Staff D was asked during that time if the medications that were drawn up were in their possession or left on top of the Pyxis machine (medication cart). Staff D confirmed that the medications were left on the Pyxis machine when putting on the lead apron. Staff D stated that other co-workers are in the procedure area during this time including the cardiac cath technicians (who do not have the authority to handle medications). Staff D did state after the interview, "probably not the best practice". On 7/11/12 it was determined that Staff D actually left the procedure room to obtain the lead apron located next to the scrub sinks.	A 405	This prompts the nurse to enter the number of doses to be withdrawn during the case. The syringes are placed in the drawer and the drawer is closed. When the nurse is ready to administer the prescribed controlled substances to the patient, he or she must log into Pyxis, select the "remove medication functionality", select "Cath Lab – Syringe Storage" that will prompt the drawer to open. The nurse then removes the medication, closes the drawer, administers the medication, then logs back into Pyxis to prompt the drawer to open, places the syringes back into the drawer and closes the drawer. Securing the medication until the next administration of medication is necessary. Monitoring: Pyxis activity reports and the MacLab Medication Events Summary will be monitored for compliance for 60 days, beginning immediately and on an ongoing basis through a systematic random audit and results reported to Quality Committee quarterly.	
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: AIA, (American Institute of Architecture) Guidelines for Design and Construction of Health Care Facilities 2.1 General Hospitals 8.2 General Standards for Details and Finishes 8.2.3.4 Ceilings	A 701	482.41 (a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. (American Institute of Architecture) Guidelines for Design and Construction of Health Care Facilities 2.1 General Hospitals 8.2 General Standards for Details and Finishes 8.2.3.4 Ceilings	8/26/2012 by Director of Materiels

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A 701	Continued From page 3 (3) Semirestricted areas (a) Ceiling finishes in semirestricted areas such as air borne infection isolation rooms, protective environment rooms, clean corridors, central sterile supply spaces, specialized radiographic rooms, and minor surgical procedure rooms shall be smooth, scrubbable, nonabsorptive, non perforated, capable of withstanding cleaning with chemicals, and without crevices that can harbor mold and bacterial growth. (b) If lay-in ceiling is provided, it shall be gasketed or clipped down to prevent the passage of particles from the cavity above the ceiling plane into the semirestricted environment. Perforated, tegular, serrated, or highly textured tiles shall not be used. Based on tour of the surgical suites on 7/12/12 with Staff F (Clinical leader of the Family Center) it was observed that the facility failed to maintain an environment to meet surgical services. Findings include: During tour of the surgical suites located within the Family center on 7/12/12 it was observed and shown to Staff F that the ceiling tiles located in the semi-restricted corridors were perforated ceiling tiles. These tiles were not scrubbable and capable of withstanding cleaning and/or disinfecting chemicals. Also these tiles failed to be clipped down or gasketed, both concerns were told to Staff F at time of finding on 7/12/12.	A 701	(a) Ceiling finishes in semirestricted areas such as airborne infection isolation rooms, protective environment rooms, clean corridors, central sterile supply spaces, specialized radiographic rooms, and minor surgical procedure rooms shall be smooth, scrubbable, nonabsorptive, non perforated, capable of withstanding cleaning with chemicals, and without crevices that can harbor mold and bacterial growth. (b) If lay-in ceiling is provided, it shall be gasketed or clipped down to prevent the passage of particles from the cavity above the ceiling plane into the semirestricted environment. Perforated, tegular, serrated, or highly textured tiles shall not be used. Action Plan: A lay-in ceiling tile with smooth, washable, non creviced, non absorptive, non perforated characteristics that can withstand cleaning chemicals shall be installed. This lay-in ceiling shall be of the gasket type to prevent the passage of particles from the cavity above the ceiling into the semi-restricted environment. Quality Assurance Measures: Ceilings in other semi-restricted areas such as airborne infection isolation rooms, clean corridors, central sterile supply spaces, specialized radiographic rooms and minor surgical procedure rooms were reviewed to ensure they meet the current ceiling finish requirements as referenced in the 2006 Guidelines For Design And Construction Of Healthcare Facilities. These results will be report to Quality Committee for acceptance and suggestions for any further action.	7/31/2012
A 747	482.42 INFECTION CONTROL	A 747		

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A 747	Continued From page 4 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on record review, interview, and review of CDC, and AORN national standards it was determined that the hospital failed to provide a sanitary environment, and avoid sources of transmission of potential infections by not developing and or implementing policy and procedures following recognized standards for 1) the cleaning and disinfecting of equipment between patient uses on five of seven distinct hospital areas, 2) the appropriate gowning when entering the room of a patient on infection precaution on one of seven areas, 3) the criteria for employees with potential infectious process for being able to work in direct patient care and 4) for allowing an employee with draining wounds to participate in an environment where invasive procedures were being performed. Findings include: CDC (Centers for Disease Control and Prevention) Recommendation and Reports "http://www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm" accessed on 6/8/12 pg 4 of 7, states "All HCWs [Health Care Workers] ....HCWs who have exudative lesions or weeping dermatitis should refrain from all direct care and	A 747	1. The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. CDC requires hospitals to provide a sanitary environment and avoid sources of transmission of potential infections by implementing policies and procedures for the cleaning and disinfecting of equipment between patients [glucometer]. On June 26, 2012 the Director of the Laboratory, Director of Education and Infection Control met with Nurse Managers to discuss glucometer cleaning between patient use. The policy PC-DI.003 was reviewed and revised to reflect current CDC recommendations and CMS requirements for cleaning between patient use. An education team comprised of 3 nurse educators developed and distributed a 2 page teaching tool to all managers in departments using glucometers. Nurse managers reviewed the information with their staff at change of shifts until all staff had been informed of and educated on the new process of cleaning the glucometers between patient use. 7/2/2012 Unit Managers /designee will monitor compliance via direct observation weekly for 6 months. Compliance reports will be sent monthly to Nursing Quality Council Infection Control Committee and Quality Committee quarterly. In addition, glucometer cleaning will be incorporated into regulatory readiness rounds, reported to unit managers monthly and Quality Committee quarterly. SEE ATTACHMENT #1- Policy PC-DI.003 "Glucose Monitoring/Screening and Quality Control". 7/2/2012 SEE ATTACHMENT #2 - "Glucometer Cleaning" SEE ATTACHMENT #3 - "Glucometer Cleaning QC"	6/26/2012 by VP Acute Care & Mgr. IC

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A 747	Continued From page 5 from handling patient-care equipment and devices used in performing invasive procedures until the condition resolves...." AORN (Association of periOperative Registered Nurses) 2009 Edition Perioperative Standards and Recommended Practices, pg 480 Recommendation XI "Activities of personnel with infections, exudative lesions, nonintact skin, and /or bloodborne diseases should be restricted when these activities pose a risk of transmission of infection to patients and other health care workers. identification, evaluation by a physician, and assessment of fitness for work performance in the perioperative setting should be required... #2. Health care workers who have exudative lesions or weeping dermatitis should refrain from providing direct patient care or handling medical devices used in performing invasive procedures. Restricting personnel who have exudative lesions, nonintact skin, or weeping dermatitis reduces the risk of transmission of bloodborne and other pathogens between workers and patients". On review of the facility's policy: Page 1 SH(IC).003 Function: Surveillance, Prevention and Control of Infection. "PURPOSE: In accordance with regulatory requirements governing infectious disease, Exeter Health Resources, Inc. (EHR) has developed a program for early identification and prompt intervention for reporting and controlling the spread of contagious diseases in the workplace. STEPS IN PROCEDURE:...	A 747	2. The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases by ensuring use of the appropriate gowning when entering the room of a patient on infection precaution. Policy IC-ISOL.005 is reviewed at clinical orientation and annually via Health Stream. Included in the review of this policy is the need for donning gowns and gloves upon entering the contact precaution patient room. The guideline for ambulating patients on precautions was reviewed and updated in June of 2012. IC attended Rehab services staff meeting to review process for ambulating patients on precautions. VP of Acute Care during her weekly rounds and Nurse Managers will monitor PPE compliance for precaution patients on their units. Monitoring is also done by ICP during regulatory readiness reviews and reported to managers monthly. Lack of compliance is brought to the attention of the person in the room at the time of the observation. QA compliance reports will be sent monthly to the Nursing Quality Council, Infection Control Committee and Quality Committee quarterly. SEE ATTACHMENT #4 - Policy IC-ISOL.005 "Contact Precautions" SEE ATTACHMENT #5 - "Staff Precaution Procedures" 3. The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. Criteria for employees with potential infectious process must be established for being able to work in direct patient care. All HCWs [Health Care Workers]... HCWs who have exudative lesions or weeping dermatitis should refrain from all direct care and from handling patient care equipment and devices used in performing invasive procedures until the condition resolves..."	6/20/2012 by VP Acute Care & Mgr. IC 6/20/2012 7/19/2012 by VP H.R. & Mgr. IC

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A 747	Continued From page 6 #2. Per Guidelines for Employees with Contagious Disease (attached), Staff Health or the manager/supervisor/CRN [Certified Registered Nurse] will determine if it is necessary to relieve the person from direct patient contact or restrict form the work place. #3. When Staff Health is unavailable, HCW must report to their manager/supervisor/CRN who will determine if it is necessary to relieve the person from direct patient contact or restrict from the work place". Page 2. "GUIDELINES FOR EMPLOYEES WITH CONTAGIOUS DISEASES" In chart form: for skin disease of Abscess, Infected acne, boils, skin lesions, impetigo, wounds, paronychia; and infective material pus, lesions, secretions; and symptoms open, draining areas; page 2 relates: Under: Can employee report to work (patient care) it states "May work if areas is adequately covered until healed". Under: Can employee report to work (non-patient care) "May work if areas is adequately covered until healed". Under: Comments "All open wounds must be covered". On interview with Staff A (Manager of Cath Lab) on 6/7/12 at 10:30 a.m. and again at 2 p.m. it was revealed through interview that Staff B (Scrub technician) had 3 open lesions and a finger cut that needed stitches at times during Staff B's	A 747	Exeter Health Resources, Inc. (EHR) has developed a program for early identification and prompt intervention for reporting and controlling the spread of contagious diseases in the workplace. SEE ATTACHMENT #6 - Policy SH(IC).003 "Reporting and Management of Contagious Diseases" SEE ATTACHMENT #7 - "Staff Health-Contagious Diseases" CAP (Corrective Action Plan)	7/19/2012 7/19/2012

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A 747	Continued From page 7 employment from date of hire on 4/11/11 until 5/16/12. On further interview with Staff A it was revealed that Staff B was asked to leave the work area several times due to weeping / discharge of fluids and blood like stains in Staff B's scrubs [clothing] including at least once during a procedure. On review of the facility's Staff Health Services report dated 9/6/2011 for Staff B it states "...[Staff B] had a procedure ...last Monday in the office, got a note to return to work. While working Tuesday, Incision bled, went back Wednesday, had more procedure performed in the office, got not [note] to return to work. On Friday, started to bleed again and ended up in ...for surgery due to incision near a blood vessel...s/p [status post] surgery ...open incision/packing in place..". On review of another report for Staff B by the facility's Staff Health Services dated 3/5/2012 it states, "...[physician] did the procedure on 2/27/12...[Staff B] oow [out of work] on 2/27, 2/28. 2/29, and 3/2/12....Incision clean and dry, healing well. No s/sx [signs and symptoms] of infection. [Staff B] is able to keep the area covered while at work. States that [doctor] told him that he could go back to work as of today, [Staff B] does not have a note...Supervisor [Staff A] notified that [Staff B] can RTW [Return to work] full duty as of today" During the complaint survey, and review of the facility's policies and procedures it was identified that there was no policy for the cleaning of glucometers between patient use. Interviews on 6/6/12 and 6/7/12 on five nursing units 3 East, 4 West, ICU, Emergency Dept. and PCU identified	A 747	A team of nurse educators, IC practitioner and Lab Director reviewed and revised policy PC-DI.003 and developed a two page teaching tool for staff. This was distributed to all managers for staff education to the new process of cleaning glucometers between patients.	6/28/2012

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A 747	Continued From page 8 no consistent methodology for the cleaning of glucometers after each patient use, some units reported cleaning only after use in precaution rooms and one unit demonstrated a sample document indicating that the cleanings were done in the morning and at night.	A 747	Monitoring compliance with cleaning between patients began 7/2012 via direct observations weekly for the next 6 months. Compliance reports will be sent to unit-managers and to the Quality Committee quarterly.	
A 748	Cross refer to tag A 749 and A 748 482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on policy review, observation, and interview the facility failed to ensure that policies and procedures were developed and implemented for the cleaning and disinfection of glucometers between each patient use and failed to ensure that policies concerning the wearing of appropriate personal protective equipment were implemented in contact precaution rooms and failed to develop policies and procedures consistent with recognized infection control standards for employees with non intact skin returning to work in direct patient care areas. Findings include: During the complaint survey, and review of the facility's policies and procedures it was identified that there was no policy for the cleaning of glucometers between patient use. Interviews on 6/6/12 and 6/7/12 on five nursing units 3 East, 4 West, ICU, Emergency Dept. and PCU identified	A 748	A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. SEE ATTACHMENT #8 - "Infection Control Plan" SEE ATTACHMENT #9 - "Infection Control Scope of Service" SEE ATTACHMENT #10 - "Infection Control Position Profile" SEE ATTACHMENT #11 - "Infection Control Board Certification" SEE ATTACHMENT #12 - "Epidemiology Services Agreement" Policy PC-DI.003 was reviewed and revised to reflect CDC recommendations. A team of 3 nurse educators, IC practitioner and Lab Director developed a two page teaching tool. This was distributed to all managers to share with their staff. Education was provided at change of shift until all staff were educated	7/20/2012 by Mgr. IC & Medical Director of Infectious Disease

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A 748	Continued From page 9 no consistent methodology for the cleaning of glucometers after each patient use, some units reported cleaning only after use in precaution rooms and one unit demonstrated a sample document indicating that the cleanings were done in the morning and at night. Review of the facility's policy and procedures dated 3/2011 Title Contract Precautions policy no.:IC-ISOL.005 revealed. Purpose: "To provide guidelines for reducing the risk of transmission of epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact) or indirect contact with environmental surfaces or patient-care items in the patient's environment". STEPS IN PROCEDURE:... #3. Gowns (clean non sterile) and gloves are required when entering the patient's room. Remove the gown and gloves before leaving the patient's environment and discard, being careful that clothing does not contact potentially contaminated surfaces. Gowns are not used again even for repeated contact with the same patient. During tour of the facility's surgical units on 6/7/12 4th floor east and south Staff C (Unit Manager) was asked which patients were under contact precaution. Staff C identified three rooms two were contact precaution and the third was droplet precautions. While on the unit a staff member was observed in a patent's room with the contact precaution sign outside the patient's door. The staff member was wearing a lab coat and was standing next to the patient's bed and did not have any contact precaution gear on. Staff C	A 748	to the revised process of cleaning glucometers. Monitoring of compliance with cleaning between patients began 7/2012 via direct observations weekly for the next 6 months. The process for glucometer cleaning has been incorporated into regulatory-readiness rounds to ensure consistency in practice for all units having glucometers. Compliance reports will be sent to unit-managers following regulatory rounds monthly and to the Quality Committee quarterly. Policy IC-ISOL.005 is reviewed at clinical orientation and annually via HealthStream. All staff have been re-educated as to appropriate PPE for precaution patients with particular emphasis to rehab services staff. In addition, the guidelines for ambulating patients on precautions were updated and reviewed with staff on 6/20/2012. Monitoring for PPE compliance for precaution patients on their units is conducted by the unit managers and the VP of Acute Care Services during weekly rounding. Monitoring is also done by IC practitioner during regulatory reviews with immediate feedback provided to staff and managers. Compliance reports are submitted to Quality Committee quarterly. As of July, 26 2012 weekly compliance monitoring for PPE on precaution patients has been 100%.	6/20/2012

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A 748	Continued From page 10 was asked during the observation who the staff member was in the patient's room, Staff C confirmed through interview that it was Staff D (Physical therapy) that was not wearing any contact precaution gear. CDC (Centers for Disease Control and Prevention) Recommendation and Reports "http://www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm" accessed on 6/8/12 pg 4 of 7, states "All HCWs [Health Care Workers] ....HCWs who have exudative lesions or weeping dermatitis should refrain from all direct care and from handling patient-care equipment and devices used in performing invasive procedures until the condition resolves...." AORN (Association of periOperative Registered Nurses) 2009 Edition Perioperative Standards and Recommended Practices, pg 480 Recommendation XI "Activities of personnel with infections, exudative lesions, nonintact skin, and /or bloodborne diseases should be restricted when these activities pose a risk of transmission of infection to patients and other health care workers. identification, evaluation by a physician, and assessment of fitness for work performance in the perioperative setting should be required... #2. Health care workers who have exudative lesions or weeping dermatitis should refrain from providing direct patient care or handling medical devices used in performing invasive procedures. Restricting personnel who have exudative lesions, nonintact skin, or weeping dermatitis reduces the risk of transmission of bloodborne and other pathogens between workers and patients".	A 748	Policy SH(IC).003 was reviewed and revised to ensure compliance with CDC and AORN recommendations. These changes were communicated to all staff via the intranet. The monthly Staff Health reports to Infection Control Committee include the number of staff evaluated for wounds, staff relieved from duty and staff cleared for return to work. This data is then reported via Infection Control to the Quality Committee quarterly.	7/13/2012

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A 748	Continued From page 11 On review of the facility's policy: Page 1 SH(IC).003 Function: Surveillance, Prevention and Control of Infection. "PURPOSE: In accordance with regulatory requirements governing infectious disease, Exeter Health Resources, Inc. (EHR) has developed a program for early identification and prompt intervention for reporting and controlling the spread of contagious diseases in the workplace. STEPS IN PROCEDURE:... #2. Per Guidelines for Employees with Contagious Disease (attached), Staff Health or the manager/supervisor/CRN [Certified Registered Nurse] will determine if it is necessary to relieve the person from direct patient contact or restrict form the work place. #3. When Staff Health is unavailable, HCW must report to their manager/supervisor/CRN who will determine if it is necessary to relieve the person from direct patient contact or restrict from the work place". Page 2. "GUIDELINES FOR EMPLOYEES WITH CONTAGIOUS DISEASES" In chart form; for skin disease of Abscess, Infected acne, boils, skin lesions, impetigo, wounds, paronychia; and infective material pus, lesions, secretions; and symptoms open, draining areas; page 2 relates: Under: Can employee report to work (patient care) it states "May work if areas is adequately covered until healed".	A 748	Changes in policy SH(IC).003 were communicated to all staff via posting on the intranet, powerpoint presentation during quarterly staff business meetings, in all departmental staff meetings and division town meetings. In addition, staff are educated on hire during corporate orientation and annually via HealthStream. The monthly Staff Health reports to Infection Control Committee include the number of staff evaluated for wounds, the number of staff relieved from duty and the number of staff cleared for return to work. This data is then reported via Infection Control to the Quality Committee quarterly.	7/13/2012

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A 748	Continued From page 12 Under: Can employee report to work (non-patient care) "May work if areas is adequately covered until healed". Under: Comments "All open wounds must be covered". On interview with Staff A (Manager of Cath Lab) on 6/7/12 at 10:30 a.m. and again at 2 p.m. it was revealed through interview that Staff B (Scrub technician) had 3 open lesions and a finger cut that needed stitches at times during Staff B's employment from date of hire on 4/11/11 until 5/16/12. On further interview with Staff A it was revealed that Staff B was asked to leave the work area several times due to weeping / discharge of fluids and blood like stains in Staff B's scrubs [clothing] including at least once during a procedure. On review of the facility's Staff Health Services report dated 9/6/2011 for Staff B it states "...[Staff B] had a procedure ...last Monday in the office, got a note to return to work. While working Tuesday, Incision bled, went back Wednesday, had more procedure performed in the office, got not [note] to return to work. On Friday, started to bleed again and ended up in ...for surgery due to incision near a blood vessel...s/p [status post] surgery ...open incision/packing in place..". On review of another report for Staff B by the facility's Staff Health Services dated 3/5/2012 it states, "...[physician] did the procedure on 2/27/12...[Staff B] oow [out of work] on 2/27, 2/28. 2/29, and 3/2/12....Incision clean and dry, healing well. No s/sx [signs and symptoms] of infection.	A 748		

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A 748	Continued From page 13 [Staff B] is able to keep the area covered while at work. States that [doctor] told him that he could go back to work as of today, [Staff B] does not have a note...Supervisor [Staff A] notified that [Staff B] can RTW [Return to work] full duty as of today"	A 748		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on record review, observation and interview with staff it was determined that the facility failed to implement professional standards for when infected hospital staff are restricted from providing direct patient care and/or are required to remain away from the healthcare facility entirely, and the facility failed to ensure that policies concerning the wearing of appropriate personal protective equipment were implemented in contact precaution rooms. Findings include: CDC (Centers for Disease Control and Prevention) Recommendation and Reports "http://www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm" accessed on 6/8/12 pg 4 of 7, states "All HCWs [Health Care Workers] ....HCWs who have exudative lesions or weeping dermatitis should refrain from all direct care and from handling patient-care equipment and devices used in performing invasive procedures	A 749	The infection control officer or officers must develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Infection Control has an active system for identifying, reporting, investigating and controlling infections and communicable disease as evidenced in policies: ATTACHMENT #13 - Policy IC(ISOL).001, Previously referenced ATTACHMENT #4 - IC(ISOL).005, ATTACHMENT #14 - Policy - IC-GEN.003, Previously referenced ATTACHMENT #6 - SH(IC).003 ATTACHMENT #15 - Policy - SH(IC).004 Examples include but are not limited to: Identifying post discharge surveillance to identify surgical site infections, total house surveillance to identify healthcare associated infections (HAI), Mon-Fri daily rounds to patient care areas for reviewing patients on precautions and identifying potential HAI, the laboratory reports organisms of epidemiological importance immediately to IC (REFERENCE ATTACHMENT #16) and all health care providers with wounds will be evaluated by staff health. Reporting: Monthly and annual nosocomial reports, monthly staff health report to include number of staff evaluated for wounds, number of staff relieved from duty and number cleared for work, monthly report from managers using glucometers regarding compliance with cleaning between patients. All to be reported quarterly to Quality Committee.	7/19/2012 by Mgr. IC & Medical Director of Infectious Disease

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A 749	Continued From page 14 until the condition resolves...." AORN (Association of periOperative Registered Nurses) 2009 Edition Perioperative Standards and Recommended Practices, pg 480 Recommendation XI "Activities of personnel with infections, exudative lesions, nonintact skin, and /or bloodborne diseases should be restricted when these activities pose a risk of transmission of infection to patients and other health care workers. identification, evaluation by a physician, and assessment of fitness for work performance in the perioperative setting should be required... #2. Health care workers who have exudative lesions or weeping dermatitis should refrain from providing direct patient care or handling medical devices used in performing invasive procedures. Restricting personnel who have exudative lesions, nonintact skin, or weeping dermatitis reduces the risk of transmission of bloodborne and other pathogens between workers and patients". On review of the facility's policy: Page 1 SH(IC).003 Function: Surveillance, Prevention and Control of Infection. "PURPOSE: In accordance with regulatory requirements governing infectious disease, Exeter Health Resources, Inc. (EHR) has developed a program for early identification and prompt intervention for reporting and controlling the spread of contagious diseases in the workplace. STEPS IN PROCEDURE:... #2. Per Guidelines for Employees with	A 749	- Monthly report from nurse managers regarding compliance with PPE for precaution patients and quarterly Infection Control report to the Quality Committee - Monthly report of compliance with hand hygiene to ICC and then to departments for review with staff. Compliance is also reported to NH Quality Commission every 6 months and Quality Committee quarterly. - Per RSA 141 report reportable diseases to NH DHHS - Mandatory reporting of certain HAI to NH DHHS and CMS using CDC 's NHSN Investigating - As part of surveillance each identified HAI is looked at to ensure it meets CDC criterion for HAI and to identify any opportunities for improvement in what, if anything, could be done differently to prevent this infection. - IC-GEN.003 speaks to the process for investigating an outbreak	7/19/2012

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A 749	Continued From page 15 Contagious Disease (attached), Staff Health or the manager/supervisor/CRN [Certified Registered Nurse] will determine if it is necessary to relieve the person from direct patient contact or restrict form the work place. #3. When Staff Health is unavailable, HCW must report to their manager/supervisor/CRN who will determine if it is necessary to relieve the person from direct patient contact or restrict from the work place". Page 2. "GUIDELINES FOR EMPLOYEES WITH CONTAGIOUS DISEASES" In chart form: for skin disease of Abscess, Infected acne, boils, skin lesions, impetigo, wounds, paronychia; and infective material pus, lesions, secretions; and symptoms open, draining areas; page 2 relates: Under: Can employee report to work (patient care) it states "May work if areas is adequately covered until healed". Under: Can employee report to work (non-patient care) "May work if areas is adequately covered until healed". Under: Comments "All open wounds must be covered". On interview with Staff A (Manager of Cath Lab) on 6/7/12 at 10:30 a.m. and again at 2 p.m. it was revealed through interview that Staff B (Scrub technician) had 3 open lesions and a finger cut that needed stitches at times during Staff B's employment from date of hire on 4/11/11 until 5/16/12. On further interview with Staff A it was	A 749		

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A 749	Continued From page 16 confirmed through interview that Staff B was asked to leave the work area several times due to weeping/discharge of fluids and blood like stains in Staff B's scrubs [clothing] including at least once during a procedure. On review of the facility's Staff Health Services report dated 9/6/2011 for Staff B it states "...[Staff B] had a procedure ...last Monday in the office, got a note to return to work. While working Tuesday, Incision bled, went back Wednesday, had more procedure performed in the office, got not [note] to return to work. On Friday, started to bleed again and ended up in ...for surgery due to incision near a blood vessel...s/p [status post] surgery ...open incision/packing in place..". On review of another report for Staff B by the facility's Staff Health Services dated 3/5/2012 it states, "...[physician] did the procedure on 2/27/12...[Staff B] oow [out of work] on 2/27, 2/28. 2/29, and 3/2/12....Incision clean and dry, healing well. No s/sx [signs and symptoms] of infection. [Staff B] is able to keep the area covered while at work. States that [doctor] told him that he could go back to work as of today, [Staff B] does not have a note...Supervisor [Staff A] notified that [Staff B] can RTW [Return to work] full duty as of today" Review of the facility's policy and procedures dated 3/2011 Title Contract Precautions policy no.:IC-ISOL.005 revealed. Purpose: "To provide guidelines for reducing the risk of transmission of epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin	A 749		

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A 749	Continued From page 17 contact) or Indirect contact with environmental surfaces or patient-care items in the patient's environment". STEPS IN PROCEDURE:... #3. Gowns (clean non sterile) and gloves are required when entering the patient's room. Remove the gown and gloves before leaving the patient's environment and discard, being careful that clothing does not contact potentially contaminated surfaces. Gowns are not used again even for repeated contact with the same patient. During tour of the facility's surgical units on 6/7/12 4th floor east and south Staff C (Unit Manager) was asked which patients were under contact precaution. Staff C identified three rooms two were contact precaution and the third was droplet precautions. While on the unit a staff member was observed in a patent's room with the contact precaution sign outside the patient's door. The staff member was wearing a lab coat and was standing next to the patient's bed and did not have any contact precaution gear on. Staff C was asked during the observation who the staff member was in the patient's room, Staff C confirmed through interview that it was Staff E (Physical therapy) that was not wearing any contact precaution gear.	A 749		