Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	530025	08/26/2015
Name of Provider or Supplier	**Street Address, City, State**	
Ivinson Memorial Hospital	255 N 30th, Laramie, WY	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0000	Ivinson Memorial Hospital was surveyed by Healthcare Licensing and Surveys, on August 24, 2015 to August 25, 2015. This survey was conducted as a Patient Safety Initiative Survey using the Quality Assessment and Performance Improvement, Infection Control, and Discharge Planning Surveyor Worksheets.
A0747	INFECTION CONTROL CFR(s): 482.42 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 observation, staff interview, review of product labels and manufacturer's directions for use, the facility failed to maintain a sanitary environment in the operating room; and failed to require staff to use acceptable practices for disinfecting equipment and environmental surfaces between patient procedures and surgeries. The facility further failed to develop and implement effective measures to address identified problems with unnecessary and unsanitary items in the operating room during surgery (A749). The cumulative effects of these deficient practices resulted in the determination that the facility failed to meet the Condition of Participation for Infection Control.
A0749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) 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 observation, staff interview, and review of manufacturer's instructions, staff failed to effectively disinfect equipment and environmental surfaces in 1 of 3 operating rooms (OR) and 1 of 2 procedure rooms. The facility further failed to remove unsanitary and unnecessary objects from the OR during surgery. The facility estimated the combination of procedures and surgeries averaged 30 to 75 patients weekly. The findings were: 1. During observation of terminal cleaning and disinfection of OR #3 on 8/24/15 from 3:15 PM to 3:47 PM the following concerns were identified: a. The environmental services technician and orderly applied a disinfectant solution to the OR table and equipment, chairs, anesthesia machine, and environmental surfaces. The orderly used a long handle mop to clean the area of the ceiling directly above the clean OR table and equipment, chairs, anesthesia machine, and adjacent environmental surfaces. He cleaned the ceiling for seven minutes, placed the mop on the floor, and assisted the environmental services technician with cleaning the overhead procedure lights, additional surfaces, and video monitor equipment. After completing this task he picked the mop up from the floor and used it again to clean the same area on the ceiling that he had cleaned prior to placing the mop on the floor. He temporarily stopped cleaning the ceiling, placed the mop head in the disinfectant solution, then resumed cleaning the ceiling. b. With the exception of the time spent cleaning the ceiling, the environmental services technician and orderly cleaned the environmental surfaces and equipment in less than three minutes; and all were visibly dry in less than a minute. Interview with the two staff during the observation revealed this was their usual cleaning and disinfecting technique for end of the day terminal cleaning. They identified the disinfectant product they were using, but stated they were not aware of any specific manufacturer requirements regarding use. c. Inspection of the disinfectant product label showed the manufacturer required a minimum of 10 minutes wet exposure to ensure effective disinfectant action. Further review of the label showed "...Blood and other body fluids must be thoroughly cleaned from the surfaces and objects before" applying the disinfectant. d. According to the 2015 Edition of Guidelines for PeriOperative Practice, Association of PeriOperative Registered Nurses: "I.e.3. Used cleaning materials (eg, mop heads, cloths) should not be returned to the cleaning solutions container. Used cleaning materials are considered contaminated and returning them to the cleaning solution container contaminates the solution. VI.b.2. Cleaning should progress from top to bottom areas. During cleaning of top areas, dust, debris, and contaminated cleaning solutions may contaminate bottom areas. If bottom areas are cleaned first, these areas could potentially be recontaminated with debris from the top areas." 2. On 8/25/15 from 9:18 AM to 9:30 AM the surveyor and director of peri-operative services observed staff as they cleaned and disinfected OR #3 after a surgery was completed and prior to the next surgery. During the observation staff mopped bloody drainage from the floor. They used the same disinfectant solution that was used for terminal cleaning. There were no attempts to clean the area before disinfection and the area did not remain wet for 10 minutes. At that time the director of peri-operative services stated she was not aware of the required minimum contact time for this product. She, then, verified staff had not been following the manufacturer's requirements for effective disinfection. 3. On 8/25/15 from 8:08 AM to 8:23 AM a procedure in the procedure room, and post-procedure room cleaning and disinfecting were observed. During the observation registered nurse (RN) #1 used a disinfectant wipe to clean environmental surfaces. He removed the unclean items from the prep table, wiped the table with the disinfectant wipe, placed a drape on the table, and arranged the instruments for the next patient. The above tasks were completed in less than three

	minutes. Inspection of the disinfectant wipe product label showed the manufacturer required 3 minutes wet exposure to ensure effective disinfectant action. At that time RN #1 and the director of peri-operative services stated they were not aware of the required wet exposure time for this product. 4. Observation on 8/24/15 from 3:15 PM to 3:47 PM in OR #3 revealed 11 magazines and newspapers were stacked on top of the anesthesia cart among other equipment and items used during surgery. Interview with RN #2 at that time revealed anesthesiologist #1 brought the magazines and newspapers from his home. She stated the magazines and newspapers remained on the cart throughout the day during the surgeries that were performed that day. She also acknowledged this was not an acceptable standard of practice. 5. Observation on 8/25 /15 at 7:07 AM in OR #3 revealed anesthesiologist #1 was administering intravenous medications to the patient on the OR table. Continued observation revealed a backpack hung from the side of the anesthesia cart positioned approximately 18 inches from the patient. When the surgeon made the initial incision and throughout the surgery, staff did not remove the backpack. At 9:18 AM when the director of peri-operative services observed the back pack in the OR she acknowledged this was a breech in safe infection control practices. She further stated she had talked with staff in the past about this problem but some of the professional staff were reluctant to change. 6. Interview on 8/25/15 at 1:14 PM with the director of peri-operative services revealed the facility used the standards set forth by the Association of PeriOperative Registered Nurses as the standard of practice for peri-operative services. She further stated the facility did not have a formalized system or surveillance process for identifying breeches in infection control practices related to the concerns identified on 8/24/15 and 8/25/15. In an interview on 8/25/15 at 2:50 PM, the infection control practitioner verified the lack of a formalized system and surveillance process.