

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150162	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/10/2012
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NAME OF PROVIDER OR SUPPLIER  FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 004972</p> <p>Survey Date: 8-6-12 - 8-10-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 08/16/12</p>	S0000		

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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S0312	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review, the facility failed to conduct a performance evaluation for 1 of 1 contracted personnel files reviewed.</p> <p>Findings:</p> <p>1. Review of the file of a Massage Therapist, PF#12, indicated PF#12 is a contracted personnel based on review of a document entitled MASSAGE THERAPY SERVICES AGREEMENT (hereinafter referred to as Agreement), dated 3-21-10, indicated:</p> <p>THIS MASSAGE THERAPY SERVICES AGREEMENT is entered into by and between SISTERS OF ST. FRANCIS</p>	S0312	<p>Annual Performance Evaluations for contracted massage therapists will be conducted during the month of individual's contract anniversary date. This is in effect as of 8/27/12. Internal plans necessary to implement the ISDOH corrective action from Women's Health Services: 1) Seek legal department review of contract to ensure the corrective action plan will not create any conflicts. Responsible Person: Manager of Women's Health Date of Completion: 8/29/12 2) Review performance appraisal tools provided from Human Resources for considered usage. Responsible Person: Manager of Women's Health Date of Completion: 8/28/12 3) Create performance tool specific to massage therapists with key</p>	09/14/2012			

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	<p>HEALTH SERVICES INC., d/b/a ST. FRANCIS HOSPITAL AND HEALTH CENTERS ("St. Francis") and [PF#12] ("<u>Contractor</u>"). (underline added)</p> <p><u>Contractor</u> is qualified to provide massage therapy services to clients of St. Francis ("Client") and its massage therapy program. (underlining added)</p> <p>St. Francis shall provide an appropriate room and restroom, bottled water for <u>Contractor</u> and St. Francis clients. (underline added)</p> <p>Other modalities may be included if approved in advance by St. Francis Hospital Women's Health Services, and only if <u>Contractor</u> provides certificate of completion. (underline added)</p> <p>2. Review of the Agreement, indicated the services to be provided are direct patient care:</p> <p>EXHIBIT A SERVICES 30 (thirty), 60 (sixty), and 90 (ninety) minute <u>massage</u> sessions. Modalities must include</p>		<p>processes included and forward to HR Department. Responsible Person: Manager of Women's Health Date of Completion: On or Before 9/14/12 4) Will maintain copy of active certificate of insurance, license and certification which will be reviewed annually on their anniversary date. An audit of 9 active massage therapist files was conducted and all documents are present and correct. Responsible Person: Manager of Women's Health Date of Completion: 8/28/12</p>	

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	<p>Swedish <u>massage</u> therapy, Deep Tissue <u>massage</u> therapy, and Personal <u>massage</u> therapy. Chair <u>massage</u> services as requested. (underline added)</p> <p>3. Review of the Agreement indicated the services are to be provided at the licensed hospital being surveyed:</p> <p>St. Francis own and operates inpatient and outpatient health care facilities at <u>8111 South Emerson Avenue, Indianapolis</u> ("Indianapolis Campus (underline added)</p> <p>4. Review of the Agreement indicated the services are to be performed for St. Francis clients:</p> <p>St. Francis shall be responsible for at least the initial scheduling of all massage therapy sessions for <u>its Clients</u>, departments, and physician offices. St. Francis shall provide voicemail for after-hour calls, and shall provide the appropriate forms, including <u>Client Consent Forms</u>, S.O.A.P. Notes, Gift Certificates, and Credit Card Forms.</p> <p>During the term of this Agreement,</p>			

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	<p>Contractor shall provide professional massage therapy services as herein described to <u>Clients of St. Francis.</u></p> <p>5. The facility was requested to provide documentation of a performance evaluation for PF#12. In interview, on 8-9-12, employee #A1 indicated there was no documentation of any performance evaluation on PF#12 and no other documentation was provided prior to exit.</p>			

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review, interview and observation, the facility failed to ensure that staff followed policy &amp; procedures for cleaning and wearing personal protective equipment on the Intensive Care Unit (ICU) and created 2 conditions which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors.</p> <p>Findings include:</p> <p>1. Review of policy/procedure 850-323, Cleaning Computers in Patient Rooms, indicated the following: "IV. Procedure: The following must be done at each dismissal cleaning: 1. Using a damp cloth wipe all surfaces, except the monitor screen, with hospital approved detergent or disinfectant." This policy/procedure was last approved on 01-01-2012.</p> <p>2. On 08-08-12 at 1033 hours staff #51, housekeeper confirmed that he/she uses</p>	S0554	<p>All Environmental Service staff have received inservice training on Policy #850-323 by Environmental Service management staff. (See attached sign-in sheets.) Monitoring will be done with the ATP meters we have started using and this will tell us if we are keeping them clean. This will be monitored for 3 months to ensure compliance. Monitoring will be observed by management personnel to prevent recurrence of improper cleaning of computers. Attachments: Inservice Sign-In Sheets (Exhibits A1 and A2), Policy: Cleaning Computers in Patient Rooms (Exhibit B) Responsible Persons: Director of Environmental Services Date of Completion: 8/31/12 Deficiencies 3-5: Hospital-wide isolation policy will be addressed with staff at department meetings and in unit huddles. Staff will be instructed to directly communicate to hospital personnel and visitors practice standard violations; i.e. inform the person to tie gown or assist the person if necessary. AICU staff meetings are scheduled</p>	08/31/2012			

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	<p>glass cleaner or water to clean computer keyboard terminals in patient rooms after patients are discharged.</p> <p>3. Review of policy/procedure Hospital Wide Isolation Policy indicated the following: "2. Contact Precautions apply to patients known or suspected to be at risk of transmitting epidemiological important organisms by direct or indirect contact. Gowns and gloves must be worn by all staff and visitors when entering room and removed before leaving the patient's room." This policy/procedure was last reviewed/revised on 11-17-11.</p> <p>4. Review of patient #6's medical record (MR) indicated the patient was placed on contact precautions.</p> <p>5. On 08-08-12 at 1035 hours, staff #52 was observed wearing an untied isolation gown into patient #6's room, T322. When doing direct patient care, the isolation gown was observed to fall down off of staff #52's shoulders onto patient #6's bed and staff #52 pulled the isolation gown up on the shoulders. This was observed to happen twice while performing direct patient care with patient #6.</p>		<p>September 4, 6, 8 and 10, 2012. Daily unit huddles by Patient Care Coordinators (PCCs) from August 24 through August 31, 2012. Feedback to Medical Director August 24, 2012. Staff are to report to leadership any refusal of employees to follow practice standards per policy. Medical director of the AICU will be provided direct feedback related to lack of compliance with the house-wide isolation policy. Ongoing monitor by all staff employed in the ICU encouraged, more specifically random audits each week for a period of four weeks (from September 1 through September 30, 2012) will be conducted by the PCCs and any non-compliance will be corrected on the spot. (See attached isolation policy.) Attachments: Hospital Wide Isolation Policy (Exhibit C) Responsible Persons: Director Critical Care Services and Unit Educator, Medical Director of AICU, Patient Care Coordinator Date of Completion: As stated above Re: Cidex, Ultrasound Team Lead immediately implemented a revised log that includes a field to document date of which the Cidex was added to the container and the date on which it expires (14 days later.) The responsibility of changing the Cidex every 14 days has been assigned to a specific technologist and in her absence the Team Lead assumes this</p>				

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	6. Review of Policy # 480.10, revised 4-12-11, entitled CIDEX OPA, USE OF NON-GLUTERALDEHYDE HIGH LEVEL DISINFECTANT (HLD), indicated the solution must be discarded		responsibility. The original Cidex container is marked with the date which it will expire after opening. The Ultrasound Team Lead had one on one communication with her full time staff and all staff were informed via e-mail of the process changes. All technologists have been informed of these recent changes. This will be added as a quality measure to the department's quality dashboard to assure compliance. In the absence of the technologist who is assigned responsibility for overseeing changing Cidex every 14 days, the Ultrasound Team Lead will audit to assure compliance. Responsible Persons: Ultrasound Team Lead Date of Completion: 8/6/12 Deficiency 9: On 8/8/12 biological and medical waste containers were removed from the storage room where clean items and food products are stored. A closet of sufficient size in the suite was cleared out and all biological and medical waste was moved to this area as the permanent area for these materials. The door to where these materials are stored has been properly labeled as Biomedical storage. Responsible Person: Cardiac Nuclear Testing Date of Completion: 8/8/12		

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	<p>after 14 days [reuse life].</p> <p>7. Review of a document entitled CIDEX SOLUTION LOG SHEET, Location/Dept US RM 5, indicated the solution was tested [used] between June 28, 2012 and July 17, 2012. Nowhere on the document was it indicated if or when, the solution was discarded.</p> <p>8. In interview, on 8-6-12 at 2:40 pm, an ultrasound staff employee indicated the solution was to be discarded every 14 days.</p> <p>9. On 8-7-12 at 2:35 pm, in the presence of employees #A3 and #A6, it was observed in the supply room of the cardiac medical group testing, there was biological waste stored in the same room with clean items and food products.</p>			

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S0570	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on document review and interview, the facility failed to ensure that the infection control committee meets at least quarterly, with membership that includes members listed by the Medical Staff Bylaws.</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Bylaws indicated the following: "9.15 Infection Control Committee 9.15-1 Composition. The Infection</p>	S0570	In order to best insure compliance with attendance from all areas, a primary and secondary member for these specialties will be identified. Both the primary and secondary members for the specialties will be invited to the Infection Control meeting. Committee members also have the ability to participate in the meeting via teleconference. Alternates will be established before the next Infection Control Committee meeting.	09/20/2012			

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	<p>Control Committee shall consist of at least one (1) representative from the Departments of Internal Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Surgery. The committee shall include the Hospital Microbiologist, the CEO or designee, and the Infection Control Coordinator."</p> <p>The Medical Staff Bylaws were last reviewed/revised on 12-07-11.</p> <p>2. Review of the Infection Control Committee meeting minutes indicated the following: at the 01-19-12 meeting, representatives from Pediatrics and the CEO or designee were absent. at the 03-22-12 meeting, representatives from Obstetrics and Gynecology, Pediatrics and Surgery were absent. at the 05-17-12 meeting, representatives from Obstetrics and Gynecology, Pediatrics, Surgery and the CEO or designee were absent. at the 07-19-12 meeting, representatives from Pediatrics and Pathology were absent.</p> <p>3. On 08-09-12 at 1135 hours, staff #54 confirmed the above Infection Control Committee members did not attend the Infection Control Committee meetings.</p>		Responsible Persons: Manager Infection Control				

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S0726	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)</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>(7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following:</p> <p>(A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based on observation, the hospital failed to ensure the confidentiality of patient records by creating a situation in which unauthorized individuals could gain access to patient records in 1 instance.</p> <p>Findings:</p> <p>1. On 8-7-12 at 11:45 am, in the presence of employees #A3 and #A6, it was observed in exam room 1 of Radiation Therapy, there were medical/radiological records stored on an open shelf which had no lock. It was also observed the room had no locking entry door or other way to</p>	S0726	<p>All treatment charts are stored in a central department location. After hours, doors on each end of the department are closed and locked. The inspector did not like the charts being located in an "unmanned" area all day. This was immediately corrected by moving the charts into a cabinet within the physics department. The physics department is staffed all day and these charts are in a locked cabinet. Responsible Person: Manager Radiation Oncology Date of Completion: 8/7/12</p>	08/10/2012			

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	secure the room. It was also observed there were no staff observed in the area to monitor who was entering the room.			

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S0932	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on document review and interview, the facility failed to ensure that the nursing staff followed established policy/procedure for nursing plan of care for 5 of 12 care plans reviewed (Patient #6, 19, 25, 27 &amp; 28).</p> <p>Findings include:</p> <p>1. Review of policy/procedure 400.15, Plan of Care, indicated the following: "VI. Procedure A. Initiating the Nursing Plan of Care (to be performed by the RN) 3. Develop the Plan of Care (must be initiated within 8 hours of admission). B. Shift Review 2. At the beginning of every shift, the oncoming RN must officially document that the Care Plan was reviewed." This policy/procedure was last reviewed/revise on 02-08-11.</p> <p>2. Review of patient #6's MR indicated the patient was admitted to the facility on</p>	S0932	<p>Education module on "Plan of Care Standards" will be re-launched to Learning Compass as a mandatory education requirement for all RN and LPN staff to be completed 10/1/12 to 10/31/12.</p> <p>Responsible Person: Director of Education</p> <p>Date of Completion: 10/31/12</p> <p>Electronic Memo outlining the documentation expectations surrounding "plan of care" will be pushed out to all RN and LPN staff via the unit managers.</p> <p>Responsible Person: Director of Nursing Practice</p> <p>Date of Completion: 8/31/12</p> <p>"Plan of care" documentation expectations will be discussed by unit managers at unit meetings scheduled during the next month.</p>	08/31/2012	

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	<p>08-06-12. Review of the patient's MR on 08-08-12 at 1045 hours lacked documentation of a Care Plan.</p> <p>3. On 08-08-12 at 1045 hours staff #60 confirmed that patient #6 had no care plan.</p> <p>4. Review of patient #19's MR indicated the patient was admitted to the facility on 06-30-12 and the care plan lacked documentation of being reviewed on the day shift on 07-02, 03 &amp; 05-12.</p> <p>5. Review of patient #25's MR indicated the patient was admitted to the facility on 02-08-12 and the care plan lacked documentation of being reviewed on the day shift on 02-09, 13, 14, 15 &amp; 18-12.</p> <p>6. Review of patient #27's MR indicated the patient was admitted to the facility on 04-24-12 and the care plan lacked documentation of being reviewed on the night shift on 04-26, 27, 28 &amp; 29-12 and 05-01 &amp; 02-12.</p> <p>7. Review of patient #28's MR indicated the patient was admitted to the facility on 06-11-12 and the care plan lacked documentation of being reviewed on the night shift on 06-11, 12 &amp; 16-12 and on the day shift on 06-12, 14 &amp; 15-12.</p>		<p>Responsible Persons: Unit Managers</p> <p>Date of Completion: 9/30/12</p> <p>Unit managers/designee will monitor "plan of care" documentation expectations on 10% of patient electronic records each week.</p> <p>Responsible Persons: Unit Managers/Designee</p> <p>Date of Completion: Ongoing</p> <p>Director of Nursing Practice will work with EPIC team to develop an electronic report that provides daily metrics on "plan of care" documentation expectations. Unit manager/designee would use daily report in monitoring compliance.</p> <p>Responsible Person: Director of Nursing Practice</p> <p>Date of Completion: 9/1/12</p> <p>Nursing policy 400.15 "Plan of Care" to be revised to reflect the just released HFAP Standards manual for 2012-2013.</p> <p>Responsible Person: Director of Nursing Practice</p> <p>Date of Completion: 10/31/12</p>		

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review and observation, the hospital failed to follow its policy for the safe handling and storage of compressed gas cylinders in 12 instances.</p> <p>Findings:</p> <p>1. Review of hospital Policy No. 941.07, entitled SAFE HANDLING AND STORAGE OF COMPRESSED GAS CYLINDERS, updated on 2-24-12, indicated storage of gas cylinders will be in containers built for that purpose, securing the bottom and upper half of the cylinder. Under no conditions will cylinders be leaned against another surface, or left out of the designated holders.</p> <p>2. On 8-6-12 at 11:50 am, in the presence of employees #A3, #A4 and #A6, it was</p>	S1118	<p>Unsecured fire extinguishers and medical gas tanks have been either removed and properly stored in the Engineering storeroom or properly secured in place. See attached engineering work orders numbered 209819, 209822, 210935, 210936, 209826, and 209834. Also see the photos showing corrected condition.</p> <p>Semi-annual safety rounds include specific inspection points that address safe handling and storage of compressed gas cylinders. Until recently the safety inspections were the responsibility of the area manager. Beginning in July of 2012 these inspections became the responsibility of a team of specialists from the Safety, Security, Engineering, Biomedical Engineering, Infection Control and Environmental Services Department to ensure a thorough</p>	08/24/2012	

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	<p>observed in the sheet metal shop, there were 2 fire extinguishers on the floor, 1 fire extinguisher on a cart and 1 acetylene tank on the floor, all unsecured by chain or holder.</p> <p>3. On 8-6-12 at 1:20 pm in the presence of employees #A3, #A4 and #A6, it was observed in the tower penthouse, there were 1 fire extinguisher on a cart unsecured by chain or holder.</p> <p>4. On 8-6-12 at 1:45 pm in the presence of employees #A3, #A4 and #A6, it was observed in the general electrical distribution room, there was 1 fire extinguisher on the floor unsecured by chain or holder.</p> <p>5. On 8-7-12 at 1:55 pm in the presence of employees #A3 and #A6, it was observed in the medical gas room, there was 1 small nitrous oxide tank on the floor unsecured by chain or holder.</p> <p>6. On 8-7-12 at 2:40 pm in the presence of employees #A3 and #A6, it was observed in the outpatient adult specialty clinic physical therapy area under construction, there were 3 fire extinguishers on the floor unsecured by chain or holder.</p> <p>7. If any of the above extinguishers and</p>		<p>and effective inspection. See the attached example of the inspection questions that pertain to safe handling of compressed gases. The engineering representative of the safety inspection team will track the number of non-compliance events associated with compressed gas cylinder handling and storage. The engineering representative will also initiate area specific training where non-compliance issues occur.</p> <p>Attachments: Engineering Work Orders 209819, 209822, 210935, 210936, 209826, and 209834. Photos showing corrected condition. (Exhibit D) Example of inspection questions that pertain to safe handling of compressed gases. (Exhibit E)</p> <p>Responsible Person: Assistant Director of Engineering</p> <p>Date of Completion: 8/9/12 and 8/24/12</p> <p>8) The alcohol-based hand sanitizer was "possibly" too close to a light switch. This ABHS was removed. In the new exam rooms (scheduled to open 8/20/12) the areas were double checked to make sure that no foam dispensers were too close</p>		

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	<p>tanks were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>8. On 8-7-12 at 11:40 am in the presence of employees #A3 and #A6, it was observed in radiation therapy exam room 1, there was an alcohol-based hand sanitizer (ABHS) on a wall directly over an electrical switch.</p> <p>9. On 8-7-12 at 2:25 pm in the presence of employees #A3 and #A6, it was observed in an ultrasound room, there was an ABHS on a wall directly above a radio plugged into an electrical outlet.</p> <p>10. The ABHS's being directly over an ignition source posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source.</p>		<p>to outlets/light switches.</p> <p>Responsible Person: Manager Radiation Oncology</p> <p>Date of Completion: 8/7/12</p> <p>9) The alcohol foam sanitizer above an electrical outlet was noted in Ultrasound. The Ultrasound Team Lead has moved any devices that may have been plugged into the outlets sitting directly below the foam hand sanitizer. Since this was a problem in only one ultrasound room, we will request on the "Do It Now" board that the hand sanitizer be moved. Radiology Manager will make the request on the "Do It Now" board.</p> <p>Responsible Person: Ultrasound Team Lead, Radiology Manager</p> <p>Date of Completion: 8/6/12</p>	

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S1150	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 2 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 8-6-12 at 12:00 noon in the presence of employees #A3, #A4 and #A6, it was observed in an equipment cleaning room, there was a flexible hose connected to a water spigot over a sink without a backflow prevention device.</li> <li>On 8-7-12 at 3:00 pm in the presence of employees #A3, and #A6, it was observed in a soiled utility room in the sleep disorders center, there was a flexible hose</li> </ol>	S1150	<p>The water spigots located in the equipment cleaning room (item 1) and in the soiled utility room of the Sleep Disorders Center (item 2) which had hoses connected to them have been replaced with spigots with an integral backflow prevention device. See attached Engineering work orders numbered 210004 and 209835 along with pictures showing corrected conditions.</p> <p>As all hospital plans for renovation and construction are reviewed by the Indiana State Department of Health for compliance with the Indiana plumbing codes which should minimize non-compliance in this area. In addition, Engineering Department personnel have been instructed to be aware of potential problems associated with hoses connected to spigots without</p>	08/10/2012			

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	connected to a water spigot without a backflow prevention device.		<p>proper backflow prevention devices and to report such conditions to their supervisor to initiate corrective action.</p> <p>Attachments: Engineering work orders 210004 and 209835. Pictures showing corrected conditions. (Exhibit F)</p> <p>Responsible Person: Assistant Director of Engineering</p> <p>Date of completion: 8/10/12 and 8/14/12</p>	

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S1164	<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 interview, the hospital failed to provide evidence of preventive maintenance (PM) for 1 piece of equipment.</p> <p>Findings:</p> <p>1. On 8-7-12 at 12:10 pm, employee #A9 was requested to provide documentation of PM on a reclining chair used in Infusion Oncology for patient treatment. No documentation was provided prior to exit.</p>	S1164	<p>Reclining chairs used in Infusion Oncology have historically not been included in the hospital maintenance management program. This oversight has been corrected by including all infusion chairs in the Biomedical Engineering Maintenance program. Please see attached copy of typical preventive maintenance and inspection work order. This deficiency should not occur again as all such equipment has been inventoried and included in the maintenance program.</p> <p>Attachments: Preventive Maintenance and Inspection Work Order (Exhibit G)</p> <p>Responsible Persons: Biomedical Engineering Manager</p>	08/24/2012	

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the hospital failed to properly keep a discharge log for 1 of 1 defibrillators.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of Policy # 400.60, revised 4-14-10, entitled CODE BLUE, indicated the code cart and emergency equipment is to be checked daily on units and departments open for business 24 hours a day / 7 days a week.</li> <li>Review of a document entitled Crash Cart/Defibrillator Log, Dept. CT, Month July, Year '12, indicated defibrillator battery and supply check daily. Further review of the document indicated there was not a Defib Check done on July 7, 8, 9, 11, 14, 15, 19, 20, 21, 22, 28 and 29.</li> <li>In interview, on 8-6-12 at 3:05 pm, hospital staff indicated the defibrillator</li> </ol>	S1168	<p>The AED was not being checked according to manufacturer recommendations. Education was provided to the nurses and they understand the need to check and sign off daily. They will also begin noting Saturday, Sunday and holidays.</p> <p>Responsible Persons: Manager Radiation Oncology</p> <p>Date of Completion: 8/7/12</p> <p>The defibrillator was located in CT. This mono-phasic code master was removed from CT on the same day deficiency was noted. We elected to do so because we have two bi-phasic monitors in IR which are next door to CT. The emergency response team chair was notified and the defibrillator was picked up. Code carts and defibrillators in Imaging and we will strategically place them to meet the needs of all Imaging areas.</p>	08/10/2012	

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	was to be checked once per day and the department was open 24 hours a day, 7 days per week. No further documentation was provided prior to exit.		Responsible Persons: CT Team Lead  Date of Completion: 8/6/12	

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S1197	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</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>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the hospital failed to have written documentation of a regular state or local fire inspection in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of documents indicated the last time a State or local inspection was conducted was on 5-13-10.</li> <li>In interview, on 8-9-12 at 1:30 pm, employee #A9 indicated there was no further documentation of such an inspection within the last year, nor was there documentation the facility had requested a State or local fire inspection during the last year. No further documentation was provided prior to exit.</li> </ol>	S1197	<p>Fire and Building Code Enforcement Inspection was conducted by the Indiana Department of Homeland Security on 8/15/12. (See inspection report.)</p> <p>In order to prevent the deficiency from occurring in the future, an annual work order will be issued to the Assistant Director of Engineering to schedule the annual State Fire Inspection. (See attached copy of work order.)</p> <p>Attachments: Indiana Department of Homeland Security inspection report dated 8/15/12. (Exhibit H) Work order to schedule the annual State Fire Inspection. (Exhibit I)</p> <p>Responsible Person: Assistant Director of  Engineering</p>	08/15/2012	