

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150015	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/02/2015
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 301 W HOMER ST MICHIGAN CITY, IN 46360
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S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 005015 Survey Date: 8-31/9-2-2015 QA: cjl 09/16/15	S 0000		
S 0178 Bldg. 00	410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a) (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system. Based on observation, the hospital failed to conspicuously post the hospital's current license in an area open to patients and the public at 1 offsite facility. Findings: 1. On 9-1-2015 at 10:20 am in the presence of employee #A1, Vice	S 0178	1. <u>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</u> License sent to director of WCCC, who on 9/2/2015,	09/02/2015

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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	President Operations and Chief Nursing Officer, and employee #A5, Director of Engineering, it was observed in the entrance lobby at the Woodland Cancer Care Center, a copy of the hospital's license was posted. Review of the license indicated the expiration date on the license was 12-31-2014.		<p>removed the 2014 license from the walk display and posed the ISDH current 2015 license as well as the current HFAP Accreditation certificate.</p> <p>2. <u>How are you going to prevent the deficiency from recurring in the future?</u></p> <p>Going forward, the Administrative Secretary/Liaison for Accreditation and Licensure, will be responsible to post all current licenses and certificates, upon official receipt, at the hospital main campus as well as all off-site locations.</p> <p>In addition, during bi-annual safety checks, we will monitor to ensure up to date licenses are posted in the hospital and all off-sites. See Attachment A - Safety checklist.</p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director,</p>	

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S 0270 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality activities for 2 contracted services for the calendar year</p>	S 0270	<p>supervisor, etc.?</p> <ul style="list-style-type: none"> · Administrative Assistant – Hospital Licensure/HFAP Accreditation See Attachment B - Revised Job Description · Woodland Cancer Care Center – Director <p>4. By what date are you going to have the deficiency corrected? Deficiency corrected on 9/2/15.</p> <p>1. <u>How are you going to correct the deficiency?</u></p>	09/25/2015

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	<p>2014.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2014 indicated they did not include review of reports for the contracted services of animal therapy and nursing.</p> <p>2. In interview on 9-2-2015 at 1:15 pm, employee #A9, Supervisor Quality Services, confirmed the above and no further documentation was provided prior to exit.</p>		<p>A. Supervisor of Quality Services met with Supervisor of Patient Excellence on 9/11/2015 to review Pet Therapy policy and identify appropriate QAPI monitors for this service; Pet Therapy Handler Requirement Compliance (Qualified/Certified, influenza vaccination, CBTs, confidentiality agreement, insurance) and Pet Therapy Canine Requirement Compliance (Qualified/Certified, up to date vaccinations).</p> <p>B. Supervisor of Quality Services met with the Director of Patient Care Services on 9/22/2015 to identify an appropriate QAPI monitor for our contracted nursing personnel. An evaluation summary of the contracted employee will be utilized and completed as the QAPI for this contracted service.</p> <ul style="list-style-type: none"> · See Attachment C – Vendor Grid · See Attachment D – Hospital Quality Council Reporting Schedule · See Attachment E – 2015 Quality Reporting Structure (organization Chart) <p>2. <u>How are you going to prevent the deficiency from recurring in the future?</u></p>		

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			<p>A. Quality Services will continue request updated contract list from Regional Support Services and Risk Management Regional Contract on a monthly basis.</p> <p>B. Quality Services will then review the updated contract list to ensure that appropriate direct patient care vendors have at minimum one QAPI indicator/monitor. This QAPI indicator will then be reported to our local Hospital Quality Council on a quarterly basis.</p> <p>-</p> <p>3. <u>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</u></p> <p>A. Supervisor of Patient Excellence will provide the Pet Therapy QAPI monitor data to the Quality Services Department.</p> <p>B. Director of Patient Care Services will provide the QAPI monitor data on our contracted nursing</p>	

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S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas		<p>personnel to the Quality Services Department.</p> <p>C. Quality Services will present all of the vendor QAPI monitor data on a quarterly basis to our local Hospital Quality Council.</p> <p>4. By what date are you going to have the deficiency corrected?</p> <p>A. Pet Therapy QAPI monitors established 9/11/2015</p> <p>B. Contracted nursing personnel QAPI monitor established 9/22/2015</p> <p>C. All Vendor QAPI data, including Pet Therapy and contracted nursing personnel, was presented at 9/25/2015 Hospital Quality Council meeting</p>	

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	<p>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 include monitors and standards for one (1) contracted service, and standards for one (1) contracted and one (1) directly-provided service, as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2014.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted service of nursing.</p> <p>2. Review of the facility's QAPI program for calendar year 2014 indicated it did not include standards for the contracted service of animal therapy and the directly-provided service of maintenance.</p> <p>4. In interview on 9-2-2015 at 1:15 pm, employee #A9, Supervisor Quality Services, confirmed all the above and no further documentation was provided prior</p>	S 0406	S 0406 Plan of Correction is the same as POC for S 0270.	09/25/2015

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S 0554 Bldg. 00	<p>to exit.</p> <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 observation, the facility created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors.</p> <p>Findings:</p> <p>1. On 8-31-2015 at 2:30 pm, in the presence of employee #A1, Vice President Operations and Chief Nursing Officer, and employee #A5, Director of Engineering, it was observed in a small housekeeping closet on an open shelf, there were 6 toilet tissue rolls and 3 large rolls of handtowels, all in no container and all having no wrapper, no cover or other means to have a protective barrier. It was also observed there was a floor janitorial basin used to change dirty mop water. This situation posed the potential for cross-contamination of the items used</p>	S 0554	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The deficiency will be corrected by assuring that all items are properly covered or placed in appropriate containers. Corrective action was taken on 9/2/15; training of EVS staff begun on the proper storage of supplies. 2. How are you going to prevent the deficiency from recurring in the future? The deficiency will be prevented from recurring by the use of a checklist for the monthly tracking of proper storage of supplies. See Attachment F – Monthly Check Log-Proper Storage of Supplies. . . Closets will be continually monitored at least on a monthly basis; training of EVS staff on the proper storage of supplies took place during weekly huddle and at Department Staff Meeting on September 30, 2015. 3. Who is</p>	09/02/2015

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S 1118 Bldg. 00	<p>on patients, employees and visitors.</p> <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. Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 4 instances.</p> <p>Findings:</p>	S 1118	<p>going to be responsible for numbers 1 and 2 above? The EVS supervisor will be responsible for the monthly monitoring of the housekeeping closets by use of the checklist as well as the training of EVS staff as to the proper storage of supplies. Reports of monitoring will be given to Infection Control Committee until 100% compliance for six (6) months, then bi-annually thereafter. 4. By what date are you going to have the deficiency corrected? The deficiency has been corrected as of 9/2/15.</p> <p>S 1118 Parts 1, 2 & 3 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · Linen Supply Room - Alcohol sanitizer was moved to a different location on 09/02/2015. See Photo</p>	10/30/2015

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	<p>1. On 8-31-2015 at 2:40 pm, in the presence of employee #A1, Vice President Operations and Chief Nursing Officer, and employee #A5, Director of Engineering, it was observed in a linen storage area at the hospital, there was an alcohol-based hand sanitizer (ABHS) affixed to the wall directly above a small refrigerator with a motor.</p> <p>2. On 9-1-2015 at 10:40 am in the presence of employees #A1 and #A5, it was observed in PET (positron emission tomography) Injector Rooms 1 and 2, at the Woodland Cancer Care Center offsite, that each contained an ABHS affixed to a wall directly above electronic computer equipment.</p> <p>3. In all of the above cases, the sanitizers being directly above an electrical ignition source.</p> <p>4. On 9-1-2015 at 10:45 am in the presence of employees #A1 and #A5, it was observed in the Block (Mold) Room at the Woodland Cancer Care Center offsite, there was a machine used for melting lead. Review of the manufacturer's manual indicated there should be quarterly monitoring for employees exposed to lead at or above the Permissible Exposure Limit and at least every six months for employees</p>		<p>Attachment G · PET Exam rooms 1 and 2 – Alcohol sanitizer was moved to a different location on 09/02/2015. See Photo Attachments H & I 2. How are you going to prevent the deficiency from recurring in the future? Maintenance staff immediately received verbal education on proper hanging procedures. Staff education will be reviewed and reinforced at the next department staff meeting on October 1, 2015, where staff will receive copies of HFAP (Healthcare Facilities Accreditation Program) standard on proper hanging procedures for ABHS. See Attachment J – HFAP Standard Chapter 19.3.2.6. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The Director of Engineering (Plant Operations) 4. By what date are you going to have the deficiency corrected? Already corrected on 09/02/2015. S 1118 Parts 4 & 5</p> <p>1. <u>How are you going to correct the deficiency?</u></p> <p>The ACM Engineering & Environmental Services company performed a lead level sampling of the Block Room at WCCC on</p>	

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	<p>exposed at or above the Action Level.</p> <p>5. The employees indicated they were unable to provide documentation of any monitoring and no other documentation was provided by exit.</p> <p>6. Review of PolicyStat ID: 918419, entitled Radiation Therapy Mold Room Safety Procedures Policy, indicated there was no reference to quarterly monitoring of employees exposed to lead at or above the Permissible Exposure Limit and nor to at least every six months for employees exposed at or above the Action Level.</p>		<p>09/22/2015 to determine if room lead levels were at or above Permissible Exposure Limits per OSHA guidelines and manufacturing guidelines. ACM has been retained by FSAHMC TO perform quarterly monitoring for employees exposed to lead at or above the permissible exposure limit and at least every 6 months exposed at or above the action Level.</p> <p>Additional testing will be performed on Oct 8 to determine environmental and employee levels. Based on those results, an action plan will be developed and implemented by October 31, 2015.</p> <p>2. <u>How are you going to prevent the deficiency from recurring in the future?</u></p> <p>AMC HAS BEEN retained by FSAHMC to perform all lead monitoring as mandated by OSHA and per manufacture guidelines.</p> <p>3. <u>Who is going to</u></p>		

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			<p><u>be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</u></p> <p>Director of Engineering</p> <p>4. <u>By what date are you going to have the deficiency corrected?</u></p> <ul style="list-style-type: none"> · 09/22/2015 Lead Level Sampling · 10/08/2015 Additional testing will be performed to determine environmental and employee lead levels · 10/31/2015 Action Plan developed implemented by October 31, 2015 <p>S 1118 Part 6</p> <p>1. <u>How are you going to correct the deficiency?</u></p> <p>The policy 'Radiation Therapy Mold Room Safety Procedures #918419 was revised on September 29, 2015, to include routine monitoring and employee exposure plan per OSHA and manufacture</p>	

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			<p>guidelines. AMC Engineering and Environmental Services company has been retained to perform the routine monitoring. See Attachment K – Revised PolicyStat ID 918419</p> <p>2. <u>How are you going to prevent the deficiency from recurring in the future?</u></p> <p>Adhere to the updated guidelines in the revised, above mentioned policy.</p> <p>3. <u>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</u></p> <p>Director of Woodland Cancer Care Center (WCCC)</p> <p>4. <u>By what date are you going to have the deficiency corrected?</u></p> <p>The deficiency was corrected as of September 29, 2015.</p>	

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S 1150 Bldg. 00	<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 a backflow prevention device as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.</p> <p>Findings:</p> <p>1. On 8-31-2015 at 3:15 pm in the presence of employee #A1, Vice President Operations and Chief Nursing Officer, and employee #A5, Director of Engineering, it was observed in the emergency generator room, there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S 1150	<p>1. <u>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</u></p> <p>Backflow prevention device was installed on September 2, 2015. See Photo Attachment L</p> <p>2. <u>How are you going to prevent the deficiency from recurring in the future?</u></p> <p>Maintenance staff will review, at the September 30, 2015 staff</p>	09/02/2015			

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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 1164 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision		meeting, how to install a backflow prevention device whenever a hose is installed to a slop sink. Inspection of Back Flow Device was added to the Boiler House Daily Rounding Log for all Mechanical Rooms. See Attachment M – Boiler House Daily Rounding Log 3. <u>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</u> The Director of Engineering - 4. <u>By what date are you going to have the deficiency corrected?</u> Backflow prevention device was installed on September 2, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150015	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/02/2015
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	<p>of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review, observation and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 4 pieces of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 8-31-2015 at 1:45 pm, employee #A5, Engineering Director, was requested to provide documentation of PM on a floor scrubber used in housekeeping. In interview on 9-2-2015 at 9:15 am, employee #A5 indicated there was no documentation and none was provided prior to exit. On 9-1-2015 at 10:45 am, in the presence of employee #A1, Vice President Operations and Chief Nursing Officer, and employee #A5, it was observed in the Block Room at the Woodland Cancer Care Center offsite, there was a machine used for melting lead. The employees were requested to provide written documentation of the most recent 	S 1164	<p>S 1164 Parts 1 & 2 1. <u>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</u> A policy with maintenance log was developed on September 28, 2015. Per the attached policy, a preventative maintenance schedule has been developed and added to the responsibilities of an existing vendor. See Attachment N – PolicyStat Policy ID 1828293 2. <u>How are you going to prevent the deficiency from recurring in the future?</u> The Department of Environmental Services will adhere to the attached policy and follow the established maintenance schedule. See Attachment O - Floor Scrubber PM Log See Attachment P - Battery Check & Fluid Log 3. <u>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</u> The Director of Environmental Services. 4. <u>By what date are you going to have the deficiency corrected?</u> · September 28, 2015 – Attached Policy was created and approved · Vendor has been notified of need to include floor scrubbers in</p>	09/29/2015

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	<p>preventive maintenance performed on the machine. No documentation was provided prior to exit.</p> <p>4. The following was observed while on tour:</p> <p style="padding-left: 40px;">a. On 8-31-15 at 1:33 PM, while accompanied by Staff Members #L9 and #L14, one physical therapy staircase was observed in the rehabilitation gym of the hospital.</p> <p style="padding-left: 40px;">b. On 9-2-15 at 9:30 AM, while accompanied by Staff Members #L8 and #L11, one physical therapy staircase was observed to be in use at the Orthopedic Health Partners off-site.</p> <p>5. In interview on 9-3-15 at 11:09 AM, Staff Member #L9 indicated there was no documentation of preventative maintenance for the physical therapy staircases observed in the rehabilitation gym of the hospital and at Orthopedic Health Partners off-site. During the interview, a request was made to Staff Member #L9 for a policy on preventative maintenance of physical therapy staircases. The staff member was unaware of such a policy and one was not provided prior to the end of the survey.</p>		<p>the next scheduled PM service check of equipment scheduled for October 14, 2015 S 1164 Part 3</p> <p>1. <u>How are you going to correct the deficiency?</u> If already corrected, include the steps taken and the date of correction. The melting pot was added to the inventory of the Plant Operations PM=Preventative Maintenance program on September 29, 2015. At which time, a PM inventory tag (label) was placed onto the melting pot. 2. <u>How are you going to prevent the deficiency from recurring in the future?</u> Frequency of inspection was established in the PM program data base and a staff member will be assigned to inspect the machine (melting pot) used for melting lead. 3. <u>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</u> Director of Engineering 4. <u>By what date are you going to have the deficiency corrected?</u> Deficiency corrected September 29, 2015. S 1164 Parts 4 & 5 1. <u>How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</u> Clinical Engineering inventoried the following listed physical therapy staircases on September 28, 2015 and entered them into the Medimizer Equipment Management</p>				

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			<p>Database. PM Inventory tags (labels) were placed onto each of the four mentioned staircases. See Attachment Q – PolicyStat Policy ID 889780 · 2 South Ortho Joint Camp · Hospital Rehab Gym · Offsite outpatient Rehab at FPN, 1225 Coolspring Avenue, Michigan City · Offsite outpatient Rehab at Omni Health Care, Chesterton, IN 2. <u>How are you going to prevent the deficiency from recurring in the future?</u> The PM inspection frequency has been setup in the Medimizer Equipment Management data base, for inspections to occur every 6 months. In addition, Therapy Staff will monitor to make sure they are inspected on time. If there are discrepancies a work order can be put into Clinical Engineering. 3. <u>Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</u> The Manager of Clinical Engineering 4. <u>By what date are you going to have the deficiency corrected?</u> The deficiency was corrected on September 28, 2015.</p>	