

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2016
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 S MAIN ST CROWN POINT, IN 46307
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S 0000 Bldg. 00	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 5/16/2016 to 5/19/2016</p> <p>Facility Number: 005107</p> <p>QA: 6/16/16 jlh</p>	S 0000	My apologies if you received doubles of 6 attachments; due to computer issues, I was unable to discern if submissions successfully uploaded on first try	
S 0362 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD</p> <p>410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>(A) Establish written protocols to identify potential organ and tissue donors.</p> <p>(B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement.</p> <p>(C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor.</p> <p>(D) Use discretion and sensitivity in contacts with potential organ donor families.</p> <p>(E) Notify the appropriate procurement organization of potential organ donors.</p> <p>(F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on documentation review and interview, the facility failed to notify Indiana Organ Procurement Organization (IOPO) for 4 hospital death in 2015.</p> <p>Findings included:</p> <p>1. In review of Franciscan St. Anthony Health Crown Point Procurement Agreement which stated, "Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the Hospital." The Hospital Procurement Agreement with IOPO was last signed</p>	S 0362	<p>Gift of Hope representative conducted education to nursing shift supervisors 12/2015 and to ED staff 1/2016; online education regarding Gift of Hope for contact hours created for nursing; Informatics conducted education regarding documenting in EHR Shift Directors to use Shift Director Deceased Patient Notification form and place initials in G of H notified column as confirmation of notification Feedback by ED manager to staff in June 2016 demonstrates 100% compliance as a result of education on process and documentation Data to be reviewed in Nursing Leadership</p>	06/30/2016

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	<p>7/1/2014.</p> <p>2. In review of Franciscan St. Anthony Health Crown Point 2015 Gift of Hope Quarterly Referral Outcomes which stated, "The Center for Medicare and Medicaid Services requires that all imminent deaths are reported to the designated Organ and Procurement Organization (Gift of Hope) before life-sustaining therapies are withdrawal or de-escalated. The Center for Medicare and Medicaid requires that all deaths are reported to the designated Organ and Procurement Organization."</p> <p>3. In review of Franciscan St. Anthony Health Crown Point 2015 Gift of Hope Quarterly Referral Outcomes reports, the following were not reported to the Gift of Hope as per hospital policies and procedures:</p> <p>A. Review of Quarter 1; 2015 Quarterly Referral Outcomes report identified a patient that died 2/17/15 and was not referred to Gift of Hope after time of death.</p> <p>B. Review of Quarter 1; 2015 Quarterly Referral Outcomes report identified a patient that died 3/14/15 and was not referred to Gift of Hope when the family considered withdrawal of the</p>		<p>Meetings, Shift Supervisor meetings, Organ and Tissue Donation Committee meetings. Data is reported to the hospital QAPI committee and to the Medical Staff Affairs Quality Improvement subcommittee of the Board of Directors every 6 months since 100% compliance has already been attained for 6 month period; reporting is ongoing Responsible person: Facility CNO</p>	

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S 0554 Bldg. 00	<p>life-sustaining support before he/she died.</p> <p>C. Review of Quarter 2; 2015 Quarterly Referral Outcomes report identified a patient that died 4/24/15 and was not referred to Gift of Hope after time of death.</p> <p>D. Review of Quarter 3; 2015 Quarterly Referral Outcomes report identified a patient that died 9/2/15 and was not referred to Gift of Hope after time of death.</p> <p>4. At 2:00 PM on 5/17/2016, staff member #4 (Quality Director) confirmed all the above and no other documentation was provided prior 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 document review, observation,</p>	S 0554	Comprehensive Outpatient	06/30/2016

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	<p>and interview, the hospital failed to provide a safe and healthful environment to minimize the risk of exposure to infection for health care workers and patients in two of two off-site locations (Comprehensive Outpatient Therapy Clinic and St. John Diagnostic Imaging Center).</p> <p>Findings include:</p> <p>A. Comprehensive Outpatient Therapy Clinic off-site facility located at 10860 Maple Lane in St. John, Indiana:</p> <p>1. Review of policies and procedures indicated a policy titled: "Moist Heat Procedure," PolicyStat ID "1082810," last reviewed "11/5/2013," read: "Commercial terrycloth will be washed in the department at a minimum of two times per month..."</p> <p>2. In interview on 5-18-2016 at 10:15 AM, Staff Member #L11, physical therapist at the Comprehensive Outpatient Therapy Clinic, indicated commercial terrycloth hot pack covers are taken to the staff member's home about every 2 weeks and are laundered at the staff member's private residence. The staff member further indicated that there is no equipment to wash laundry at the off-site facility.</p> <p>B. St. John Diagnostic Imaging Center</p>		<p>Therapy Clinic: Immediate action taken May 20, 2016 and hot packs were labeled and sent to laundry. Moist Heat Procedure Policy and Procedure have been revised to address laundering and tracking of hot pack covers New process monitored and results to be reported to hospital QAPI committee monthly for a minimum of 6 months If compliance is consistent at 100%; QAPI committee will evaluate need for continued monitoring Responsible person: Clinical Manager of Outpatient Services St John Diagnostic Imaging Center: Inventory Control policy updated to alleviate expired supplies from inventory, an expired inventory form will be utilized when inventory is checked weekly Inservice education of staff to new policy concluded 6/30/2016 Monitoring of process will be conducted and reported monthly to the QAPI Committee for a minimum of 6 months; if compliance is consistent at 100%, the QAPI Committee will determine need for ongoing monitoring Responsible person: Laboratory Site Director Organizing and Sanitizing policy has been updated to clarify appropriate disinfecting agents to be used and proper disposal of potentially infectious waste; Inservice education of staff to new policy concluded 6/30/2016 Monitoring of appropriate</p>				

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	<p>off-site facility located at 10860 Maple Lane in St. John, Indiana:</p> <p>1. Review of policies and procedures indicated the following:</p> <p>a. A policy titled: "Inventory Control," PolicyStat ID "1616773," last revised "6/24/2015," read: "...any item that will expire within three (e) days will be pulled from service..."</p> <p>b. A policy titled: "Disinfection and Cleaning," PolicyStat ID "2369856," last revised "5/7/2014," read: "At the end of every work day or when work surfaces becomes contaminated, the Technician/lab aide in each department is responsible for disinfecting the work surfaces, instrument, keyboards, shields (protective eyewear, desk shield, or face shield and sinks.)..." and "Wipe work area with a Caviwipe..."</p> <p>c. A policy titled: "Cleaning and Disinfection/Sterilization of Patient Care Items Policy," PolicyStat ID "2381610," last revised "4/22/2016," indicated "PDI Super Sani Cloth wipes" and "PDI Sani Cloth Bleach" are the only disinfectants approved for use on "environmental surfaces." "Clorox Clean-Up" spray and "Clorox Disinfecting Wipes" were not included on the list of hospital approved disinfectants.</p> <p>2. During laboratory tour on 5-18-2016 at 10:35 AM, the following was observed:</p>		<p>disinfection agent and proper disposal of will be performed by the supervisor and reported monthly to the QAPI Committee; if compliance is 100% for a minimum of 6 months, the QAPI Committee will determine need for ongoing monitoring Responsible person: Laboratory Site Director</p>	

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	<p>a. Seven (7) 40 milliliter (mL) bottles labeled "BD Bactec Lytic/ 10 Anaerobic / F Culture Vials," lot number "5B9718," expiration date "2016-03-31" stored in a wall cabinet over the laboratory counter top.</p> <p>b. Twenty (20) "ChlorPrep One-Step 2% w/v Chlorhexidine gluconate (CHG) and 70% w/v isopropyl alcohol (IPA) Patient Preoperative Skin Preparation 1.5 mL FREPP Applicators," lot number "61400," expiration date "03/16," stored in a wall cabinet over the laboratory counter top.</p> <p>c. One unopened fifty (50) count box of "Covidien Curity Sheer Adhesive Bandage," lot number "B1210141," expiration date "2015 12" stored in a wall cabinet over the laboratory counter top.</p> <p>d. One unopened 50 count box of "Covidien Curity Sheer Adhesive Bandage," lot number "B1210160," expiration date "2016 01" stored in a wall cabinet over the laboratory counter top.</p> <p>e. A sink supplied with hand soap and paper towels that had an eyewash attached to the sink faucet. A noticeable urine-like odor was coming from the sink area.</p> <p>f. A spray bottle of "Clorox Clean-Up" and a container of "Clorox Disinfecting Wipes" on the counter top next to the sink.</p>			

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S 0594 Bldg. 00	<p>3. In interview on 5-18-2016 at 10:58 AM, Staff Member #L12 (Phlebotomist) acknowledged the expired laboratory supplies and indicated 24 hour urine samples are disposed down the laboratory sink that is supplied with hand soap, paper towels, and an eye wash. The staff member further indicated the "Clorox Clean-Up" was used to disinfect the sink after disposal of urine samples down the sink, and the "Clorox Disinfecting Wipes" were used to disinfect the laboratory counter tops.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ii) Universal precautions, including infectious waste management.</p> <p>Based on document review, observation and interview, the facility failed to ensure the infection control committee was monitoring and guiding the infection</p>	S 0594	In the current state, two soiled utility rooms exist; We will combine the soiled utility into one room and will repurpose the other room as "processing" where	08/01/2016	

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	<p>control program related to universal precautions of infectious waste management in 2 of 3 (Obstetrics Department Soiled Utility Room) areas toured.</p> <p>Findings:</p> <p>1. Policy #1004839, Handling and Disposal of Infectious Waste, revised/reapproved on 10/14/13 indicated on pg. 1, under Purpose Statement section:</p> <p>A. point 1. a., "Infectious waste shall be defined as: those wastes that, in all probability, contain pathogenic agents that, because of their type, concentration and quality, may cause disease or injury in persons exposed to the waste."</p> <p>B. point 2., "adherence to appropriate practices shall be necessary to improve waste management and to better protect the health and safety of employees, patients, and visitors."</p> <p>2. While on tour of the Obstetrics Department on 5/19/16 at 1115 hours, accompanied by staff 2 (Vice President of Patient Services and Chief Nursing Officer [CNO]), it was observed that:</p> <p>A. one Soiled Utility Room had a microscope on a small corner shelf desk area used to view specimens.</p> <p>B. one Soiled Utility Room had a</p>		<p>microscopic viewing of specimens and processing of cord blood specimens can be performed; Signage for the processing room has been ordered Staff will be educated and information will be disseminated to all departments Anticipated go live date is 8/1/2016 Responsible person: Director of Birthplace Unit</p>	

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S 0954 Bldg. 00	<p>processing area for cord blood and clean cord blood storage boxes used to ship the cord blood after processing.</p> <p>C. both Soiled Utility Rooms had storage of used biohazard bags and hoppers used to dispose of possibly infectious waste.</p> <p>3. Staff 2 was interviewed on 5/19/16 at approximately 1300 hours and confirmed the above-mentioned Soiled Utility Rooms had storage of used biohazard bags and hoppers used to dispose of possibly infectious waste and specimens were either being viewed or processed. Processing of specimens should not be done in Soiled Utility Rooms and clean supplies should not be stored in Soiled Utility Rooms to prevent transmission of dangerous communicable diseases.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(e)</p> <p>(e) Emergency equipment and emergency drugs shall be available for use on all nursing units. Based on document review, observation and interview, the facility failed to ensure the availability of emergency equipment</p>	S 0954	Situation immediately corrected; Radiology Manager reviewed policy with staff regarding offsite	06/30/2016			

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	<p>and emergency drugs for 1 of 2 (Franciscan Physician Network Lowell Health Center) outpatient areas toured.</p> <p>Findings:</p> <p>1. Policy #1023477, Response to Persons Needing Emergency Medical Assistance, revised/reapproved on 8/26/13 indicated on pg. 2, under Off Campus Location section, point 1., "In the event of a potential medical emergency at a non-hospital Franciscan St. Anthony Health - Crown Point (FSAH-CP) site, 911 and security (if available) should be called. While waiting for response, appropriate first aid care, CPR, containment of bleeding and/or comfort care is to be offered consistent with good medical practice (which may be 'doing no harm' and not moving the person) depending upon the level of training and experience of the associate on the scene."</p> <p>2. While on tour of the facility on 5/18/16 at 0930 hours, accompanied by staff 32 (Interim Imaging Manager), it was observed that the Emergency Kit was inaccurate and/or not complete due to:</p> <p>A. suction kits, cardiopulmonary resuscitation (CPR) shields, silk tape and blood pressure cuffs (adult and pediatric) were present, but not documented on the list.</p>		<p>process for emergency situations which entails calling 911 and provision of basic first aid care, CPR, containment of bleeding and/or comfort care Radiology services can provide care outlined in policy utilizing supplies in the hospital services area of the clinic which negates the need for private physician office emergency bag within shared clinic context, thus those supplies from the private office emergency bag will not be utilized going forward Responsible person: Radiology Manager The private provider side who owns the emergency bag is out of scope for acute care action since the private provider side of the clinic is not under hospital CCN; however, in the spirit of quality patient care, the office supervisor was notified of issues in order to take corrective action</p>	

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S 1022 Bldg. 00	<p>B. items not in the kit, but documented on the list: chewable aspirin, Epi-pen Jr, ambu bag with mask (adult and pediatrics), pediatric oral airways and gloves.</p> <p>C. expired meds of Aspirin 325 mg (expired 2/16) and Nitroglycerin (sublingual) 0.4 mg (expired 4/16).</p> <p>D. items were very disorganized and adult oral airways of 8.0 MM, 0.9 MM and 10.0 MM were stored haphazardly in the bottom of the bag and difficult to find.</p> <p>E. no monthly log for checking the accuracy of the emergency equipment and emergency drugs in the Emergency Kit.</p> <p>3. Staff 32 (Interim Imaging Manager) was interviewed on 5/18/16 at approximately 1000 hours and confirmed the above-mentioned Emergency Kit was shared by the Diagnostic Imaging Department and the Franciscan Physician Network Lowell Health Center and lacked an accurate and/or complete list of supplies, had expired medications, lacked a monthly check log and was disorganized.</p>			
	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)			

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	<p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on document review, observation and interview, the facility failed to ensure appropriate storage conditions for medications according to facility policy and procedure for 1 of 2 (Franciscan Point Surgery Center Surgical Sterile Core) outpatient areas toured. Findings:</p> <p>1. Policy #1950056, High-Alert Medications, revised/reapproved on 12/11/15 indicated on pg. 1, under Key Points section, points 1. and 4.e., "HIGH-ALERT MEDICATIONS are drugs that have a HIGH RISK OF CAUSING INJURY, either as a result of a narrow therapeutic range or high incidence of errors - as reported by the Institute of Safe Medication Practices (ISMP)...High-alert medications will have mechanisms in place to minimize the risk of patient harm. These actions may include, but are not limited to...Special packaging and/or labeling."</p> <p>2. Review of the High Alert Medication</p>	S 1022	<p>Deficiency has been corrected: By 1500 on 5/19/16, all neuromuscular blockers at Franciscan Point Surgery Center were placed in high alert baggies as described by the High Alert Medication Policy All pharmacy technicians involved with stocking of medication at the Franciscan Point Surgery Center were educated on appropriate storage of neuromuscular blockers on 5/19 and 5/20/16 Monitoring: Neuromuscular blocker storage will be monitored daily to ensure proper storage; Monitoring will be reported monthly to the QAPI Committee for a minimum of 6 months; if compliance is consistent at 100%, the QAPI Committee will evaluate need for continued reporting Responsible person: Director of Pharmacy</p>	06/30/2016

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 S MAIN ST CROWN POINT, IN 46307
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S 1118 Bldg. 00	<p>List revised/reapproved on 3/17/16 confirmed on pg. 6, Neuromuscular Blockers are High Alert Medications and "all Pyxis stock vials stored in a separate baggie labeled with cautionary sticker."</p> <p>3. While on tour of facility on 5/18/16 at 1020 hours, accompanied by staff 34 (Nurse Manager), it was observed that high-risk/high-alert medications of Rocuronium and Succinylcholine vials were not stored in a separate baggie labeled with a cautionary sticker in the Pyxis.</p> <p>4. Staff 25 (Director of Pharmacy) was interviewed on 5/19/16 at approximately 1320 hours and confirmed the above-mentioned medications of Rocuronium and Succinylcholine are high risk/high alert medications and were not stored according to policy and procedure.</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</p>			

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	<p>maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on documentation review, observation, and interview, the hospital failed to provide a safe setting for staff in two restrooms.</p> <p>Findings included:</p> <ol style="list-style-type: none"> In review of Franciscan Alliance Electrical Safety Policy stated, "Keep fluids and chemicals away from equipment." The policy was last reviewed 12/8/2015. At 10:30 AM on 5/17/2016, the administrative Men and Lady's restrooms were observed with their wall mounted hand soap dispenser mounted directly above an electrical socket. The two soap dispensers did not have a splash guard under the dispensers. A person must put their hands under the dispensers next to the electrical outlets. The two soap dispensers were mounted two inches above both electrical outlets. In interview at 12:15 PM on 5/17/2016, staff member #15 (Maintenance Supervisor) confirmed all the above. 	S 1118	<p>Soap dispenser: The administration restroom soap dispenser was removed and relocated on 5/19/2016; all facility restrooms were assessed to ensure the soap dispenser installations were in compliance and properly installed</p> <p>Responsible person: Director of Engineering/Maintenance Food & Nutrition light sensitive bottles: Upon discovery on May 19, the product was placed in brown paper bags to protect from light</p> <p>A dietary department meeting was held on May 26 at which time proper storage of product was discussed; this was followed by an update to the policy on tube feeding storage which includes directions for keeping the product in its original box in order to assure proper storage</p> <p>The department manager and or department supervisors will evaluate storage appropriateness on a daily basis</p> <p>Compliance with tube feeding storage policy will be reported monthly to the QAPI Committee for a minimum of 6 months; if compliance is consistent at 100%, the QAPI Committee will evaluate the need for further reporting</p> <p>Responsible person: Administrative Director, NI Food and Nutrition Services</p> <p>Unlocked soiled utility rooms: Locks and cylinders have been ordered for all soiled utility rooms</p>	09/30/2016

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	<p>Based on observation and staff interview, the hospital failed to store therapeutic nutrition in accordance with manufacturer's recommendations.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During kitchen tour on 5-18-2016 at 10:45 AM, the labels on the following therapeutic nutrition bottles read "Contains light-sensitive nutrients." The bottles were observed on a shelf in the dry storage room, unprotected from light: <ol style="list-style-type: none"> a. Four 1.1 quart bottles of "Nepro with Carb Steady." The label on the bottle read "Contains light-sensitive nutrients." b. Four 1.6 quart bottles of "Glucerna 1.2 Cal." The label on the bottle read "Contains light-sensitive nutrients." c. Three 1.1 quart bottles of "Vital AF 1.2 Cal." The label on the bottle read "Contains light-sensitive nutrients." 		<p>Expected delivery is 7/29/16; badge readers controllers and electronic door strikes anticipated delivery is 8/15/16; installation of all equipment will be completed by 9/30/16 Responsible person: Director of Engineering/Maintenance</p>	

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	<p>d. Two 1.1 quart bottles of "TwoCal HN." The label on the bottle read "Contains light-sensitive nutrients.</p> <p>2. In interview on 5-18-2016 at 10:45 AM, Staff Member #L13 acknowledged the above therapeutic nutrition bottles should be protected from light when stored.</p> <p>Based on observation, document review and interview, the facility failed to ensure no condition was created or maintained that may result in a hazard to patients, visitors, and/or employees due to Soiled Utility Rooms not being locked in 5 of 8 (Emergency Department [ED], Post Anesthesia Care Unit [PACU], Obstetrics Department, Nuclear Department, and Outpatient Franciscan Point Surgery Center) areas toured.</p> <p>Findings:</p> <p>1. While on tour of facilities on 5/17/16 at 1009 and 1045 hours, 5/18/16 at 0930 and 1020 hours, and 5/19/16 at 1115 hours, accompanied by staff 2 (Vice President of Patient Services and Chief Nursing Officer [CNO]), it was observed that the Soiled Utility Rooms located in</p>			

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	<p>the ED, PACU, Obstetrics Department, Nuclear Department, and Outpatient Franciscan Point Surgery Center were not locked.</p> <p>2. Policy #1004839, Handling and Disposal of Infectious Waste, revised/reapproved on 10/14/13 indicated on pg: A. 1, under Purpose Statement section, "adherence to appropriate practices shall be necessary to improve waste management and to better protect the health and safety of employees, patients, and visitors." B. 2, under Procedure section, point 5, "the storage area will be secured to eliminate general access by or exposure to the general public."</p> <p>3. According to 410 IAC 1-3-25 Storage; Authority: IC 16-19-3-4; IC 16-41-16-8; Affected: IC 16-41-16: Sec. 25.: If infectious waste is stored prior to final disposal, all persons subject to this rule shall: (1) store infectious waste in a secure area that: A) is locked or otherwise secured to eliminate access by or exposure to the general public.</p> <p>4. Staff 2 (Vice President of Patient Services and CNO) was interviewed on 5/19/16 at approximately 1300 hours and confirmed Soiled Utility Rooms are to be</p>			

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S 1172 Bldg. 00	<p>secured per facility policy and procedure and were not for the above-mentioned locations.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on documentation review, observation and interview, the hospital failed to keep clean and orderly the environment and equipment for the Central Sterile decontamination area.</p> <p>Findings included:</p> <p>1. In review of Franciscan Alliance Cleaning of the Storing, Washing,</p>	S 1172	Central Decontamination area floor: To assist environmental services with maintaining cleanliness of the central decontamination area floor, maintenance will begin prepping and repainting the floor in this area on 7/5/16; due to time required for prepping, painting, and curing in a high traffic area, the target completion date is 7/29/16 Responsible person: Director of Engineering/Maintenance Floors	07/29/2016

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	<p>Processing, Distributing, Linen Services Department & S.P.D. policy which stated, "To provide a clean environment for the decontamination, laundering, packaging, and sterilizing, process stores, corridors, lifts and the offices. Environmental Services Department will clean these areas on both a daily and periodic basis. Daily cleaning will include emptying the waste baskets, cleaning the basins, spot washing the walls, office cleaning and window cleaning. The entire department floor will be thoroughly vacuumed and damped mopped. The periodic cleaning will include thoroughly washing of all the ceiling lights, vents, and walls." This policy was last reviewed 5/16/2013.</p> <p>2. At 11:15 AM on 5/18/2016, the Central Sterile decontamination area was toured. The decontamination area was located in the laundry/linen Department; which had a pass-through wall between the clean room and the decontamination area. However, the decontamination area was separated from the laundry/line and cart storage with yellow tape striped on the cement floor. The cement floor surface of the decontamination processing area was observed green. This separation identified restriction to personnel the access into the decontamination processing area. The</p>		<p>will be swept and damp mopped daily, and scrubbed weekly according to policy; Inspections will be conducted by the Evening EVS Supervisor and performance results will be reported to the QAPI Committee quarterly ongoing as part of regular EVS quality reporting Person responsible: EVS Supervisor</p>	

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	<p>decontamination floor surface area was observed with loose debris around the edges of the room. The green painted cement floor was observed with soil residue covering the entire floor surface.</p> <p>3. In interview at 10:30 AM on 5/18/2016, staff member #21 (Central Sterile Lead Tech) confirmed the decontamination floor surface was dirty and there was loose debris on the floor around assorted equipment. The staff member indicated the floor was supposed to be scrubbed with the floor scrubber once a week and he/she cannot remember when the floor surface was last scrubbed by the Environmental Service (EVS) Department.</p> <p>4. In interview at 11:15 AM on 5/19/2016, staff member #22 (EVS Supervisor) confirmed the floor of the decontamination area has not been scrubbed weekly as required.</p> <p>5. In interview at 1:30 PM on 5/19/2016, staff member #15 (Operations and Maintenance Manager) confirmed all the above and no other documentation was provided prior to exit.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ANTHONY HEALTH - CROWN POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 S MAIN ST CROWN POINT, IN 46307		
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