

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 05/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 004972 Survey Date: 05-23-2016 - 05-25-2016 QA: 6/24/16 jlh	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 and interview, the hospital failed to post the Indiana State hospital license in a conspicuous location for 2 off-sites. Findings included: 1. At 1:00 PM on 5/24/2016, the St. Francis Neurology Testing Center off-site was observed without the Indiana State hospital license conspicuously posted in an area open to patients and visitors.	S 0178	This was corrected the day of finding 5/24/2016. Will institute process for Accreditation Coordinator to review posting of all licenses with renewal each year. Measurement of sustainability will be completed by adding metric to readiness/Safety rounding worksheets.	05/25/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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 0308 Bldg. 00	<p>2. At 1:25 PM on 5/24/2016, the St. Francis OB/GYN - Mammography off-site was observed without the Indiana State hospital conspicuously posted in an area open to patients and visitors.</p> <p>3. At 11:15 AM on 5/25/2016, staff member #A1 (Director of Patient Safety) confirmed all the above.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the hospital failed to document evidence of General Orientation for 6 of 12 employee files reviewed.</p>	S 0308	Our plan will be to modify the current General Orientation Policy to indicate that new employees must attend General Orientation, but define that 1) education must be contacted for records and where those records exist given	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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 0554 Bldg. 00	<p>Findings include:</p> <ol style="list-style-type: none"> Review of PolicyStat ID: 1301750, entitled General Orientation Policy, Last Revised: 7/28/2013, indicated "All new employees must attend General Orientation" Further review of the above-stated policy indicated there were no exceptions for contracted employees. Review of 12 personnel files indicated files P1, contract scribe, P2, radiology tech, P3, Pharmacy Director, P4, Maintenance department, P5, Housekeeping Director, and P12, contract Medial Records Director, did not contain any documentation of general orientation, per facility policy. Interview of employee #A22, Human Resources Generalist, on 5-23-2016 at 11:00 am, confirmed the above and no other documentation was provided prior to exit. <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</p>		<p>when the employee attended orientation. This should address points 1, 3, and 4. We will also indicate that contract employees must have a general orientation (shortened version assigned via Learning Compass), and that this is the responsibility of the manager. This should address point 2.</p> <p>Measurement of sustainability will be completed by adding metric to employee file worksheet checklist.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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																														
	<p>to patients, health care workers, and visitors.</p> <p>Based on observation and document review, the facility failed to ensure nutritional supplements were stored according to manufacturers guidelines for nine (9) types of nutritional supplements stored.</p> <p>Findings include:</p> <p>1. On 05-23-2016 at 1:30 pm in the presence of employees #A12, Engineering Supervisor and #A17, Engineering Manager, it was observed in the General Stores area there were 219 1.1 quart each containers of nutritional supplement as follows, stored on an open wire rack shelves, uncovered and unprotected, completely exposed to fluorescent light (high intensity artificial light):</p> <table border="0"> <tr> <td>Vital AF 1.2 cal</td> <td>29</td> <td></td> </tr> <tr> <td>containers</td> <td></td> <td></td> </tr> <tr> <td>Glucerna 1.2 cal</td> <td>28</td> <td>"</td> </tr> <tr> <td>Jevity 1.2 cal</td> <td>54</td> <td>"</td> </tr> <tr> <td>TwoCal HCN</td> <td>20</td> <td>"</td> </tr> <tr> <td>Jevity 1.5 ca</td> <td>24</td> <td>"</td> </tr> <tr> <td>Promote</td> <td>18</td> <td>"</td> </tr> <tr> <td>Nepro</td> <td>14</td> <td>"</td> </tr> <tr> <td>Osmolite 1.2 cal</td> <td>17</td> <td>"</td> </tr> <tr> <td>Vital High Protein 1.2 cal</td> <td>15</td> <td>"</td> </tr> </table>	Vital AF 1.2 cal	29		containers			Glucerna 1.2 cal	28	"	Jevity 1.2 cal	54	"	TwoCal HCN	20	"	Jevity 1.5 ca	24	"	Promote	18	"	Nepro	14	"	Osmolite 1.2 cal	17	"	Vital High Protein 1.2 cal	15	"	S 0554	<p>Central Supply is now the only hospital location housing Enteral feedings. Enteral feedings have all been pulled from the nursing units. We changed to storing them in plastic tubs. As stock comes in it is removed from the cardboard container and placed into plastic tubs. The plastic tubs have lids and seal out any light. Now a feeding is sent to the nursing unit when the nurse calls Central Supply and requests a specific type of feeding for the patient. Only the feeding needed is sent to the unit. So there are no bottles sitting around in sunlight or under artificial lights. Measurement of sustainability will be completed by adding metric to readiness/Safety rounding worksheets.</p>	06/01/2016
Vital AF 1.2 cal	29																																	
containers																																		
Glucerna 1.2 cal	28	"																																
Jevity 1.2 cal	54	"																																
TwoCal HCN	20	"																																
Jevity 1.5 ca	24	"																																
Promote	18	"																																
Nepro	14	"																																
Osmolite 1.2 cal	17	"																																
Vital High Protein 1.2 cal	15	"																																

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 05/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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 0594 Bldg. 00	<p>2. Review of the manufacturer's label on each bottle indicated "contains light sensitive nutrients"</p> <p>3. Interview of facility staff on 05-23-2016 at 1:20 pm, indicated the lights were on for virtually 24 hours.</p> <p>4. Review of a document from the manufacturer entitled Abbott Nutrition RTH and Hi-Cal Light Statement Frequently Asked Questions, dated JANUARY 2013, indicated the following:</p> <p>" Long-term exposure to direct sunlight or high intensity artificial light degrades vitamins such as riboflavin (B2), B6, and vitamin A."</p> <p>"Store product in the shipper as long as possible or store on covered shelves or in a closed cabinet prior to use."</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</p>			

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 05/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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
	<p>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 provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors by failing to follow universal precautions related to infectious waste management by storing clean supplies in soiled utility room in 1 of 15 (Dialysis Unit) areas toured; and failed to ensure appropriate cleaning of equipment in 1 of 15 (Sports Medicine Therapy) areas toured.</p> <p>Findings:</p> <p>1. PolicyStat ID: 1739676, Infection Prevention Physical Therapy and Outpatient Rehabilitation Services Policy, revised/reapproved on 9/29/15 indicated, general cleaning of environment and equipment: Use a hospital-approved detergent/disinfectant to clean equipment that comes in contact with patients, or when visible soilage is present.</p>	S 0594	<p>1 & 3. Physical Therapy, Outpatient Rehabilitation Services, and Rehab Services will implement a process that all equipment that comes into contact with patients will be cleaned between patient use with a hospital-approved detergent/disinfectant.</p> <p>2 & 4. Additional storage will be put into place in the dialysis unit to store clean items so no clean items will be in the solid utility rooms.</p> <p>Measurement of sustainability will be completed by adding metric to readiness/Safety rounding worksheets.</p>	07/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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 0598 Bldg. 00	<p>2. While on tour of facility on 5/24/16 at approximately 1100 hours, accompanied by staff N8 (Accreditation Coordinator), clean items for patient care use were observed stored in the soiled utility room on the Dialysis Unit.</p> <p>3. While on tour of facility on 5/24/16 at approximately 0915 hours, in the presence of staff N2 (Director of Patient Safety), staff N6 (Director of Rehab Services) and staff N7 (Manager Rehab Services) confirmed equipment is not cleaned after each patient contact.</p> <p>4. Staff N9 (Dialysis Manager) was interviewed on 5/24/16 at approximately 1115 hours and confirmed clean items are stored in the soiled utility room on a routine basis due to lack of clean storage area on the unit. Staff N9 confirmed storage of clean items for patient care use should not be stored in soiled utility room.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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
	<p>program in the facility as follows:</p> <p>(3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on documentation review, observation, and interview, the hospital failed to ensure 2 off-sites were complying with Federal Drug Administration (FDA) requirements related to Ultrasound Gel containers.</p> <p>Findings included:</p> <p>1. Review of FDA Alert and Notification states, "Ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. once a container of sterile or non-sterile ultrasound gel is opened, it is no longer sterile and contamination during ongoing use is possible. Use open containers of ultrasound gel for low risk procedures on intact skin and for low risk patients. Never refill or 'top off' containers of ultrasound gel during use. The original container should be used and then discarded. past studies have</p>	S 0598	<p>All ultrasound gel is ordered through Central Supply. Central Supply has removed bulk gel containers from stock and order forms.</p> <p>Measurement of sustainability will be completed by adding metric to readiness/Safety rounding worksheets.</p>	06/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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 0612	<p>demonstrated that ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades." The FDA notification was posted June 8, 2012.</p> <p>2. At 1:00 PM on 5/24/2016, the St. Francis Neurology Testing Center off-site departments ultrasound gel storage area was inspected. The storage area had a half filled bulk gel container with partially filled gel bottles.</p> <p>3. At 1:25 PM on 5/24/2016, the St. Francis OB/GYN - Mammography off-site departments ultrasound gel storage area was inspected. The storage area had a half filled bulk gel container with partially filled gel bottles.</p> <p>4. At 1:30 PM on 5/24/2016, staff member #A24 (Off-site Manager) indicated the ultrasound gel bottles are refilled with the bulk gallon gel container. The staff member indicated he/she did not realize that ultrasound gel containers are not to be refilled.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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
Bldg. 00	<p>410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on documentation review, observation, and staff interview, the hospital failed to ensure clean laundry and linen were stored in a clean and sanitary environment in 7 instances and failed to replace linens after patient discharge in patient rooms.</p> <p>Findings included:</p> <p>1. Facility Linen Handling - Clean Linen Policy states, "All linen will be in approved cabinets, carts, covered shelving, or plastic covers. Handle linens as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen." The policy last was last approved 6/10/2015.</p>	S 0612	<p>2,3,& 4 All linen will be stored on covered lining carts. This metric will be added to quality quarterly environment rounds for verification and removal of barriers</p> <p>6 All lines will be removed from patient rooms at discharge, including closed linen cabinets, this action item will happen immediately. We will also look into a process for wrapped linen packs. Measurement of sustainability will be completed by adding metric to readiness/Safety rounding worksheets.</p>	06/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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
	<p>2. It was observed on 05-23-2016 at 1:30 pm, in the presence of employees #A12, Engineering Supervisor and #A17, Engineering Manager, in the Clean Linen Storage area, there was patient linen stored on 2 open wire shelves and there were 4 stacks of scrub suits on top of storage cabinets. The linen was not covered or stored per facility policy.</p> <p>3. It was observed on 5/24/2016 at 11:00 am in the Sleep Center off site store room , in the presence of #A25 (Sleep Center Manager); shipping cartons were stored directly over uncovered clean folded assorted linen on a wired shelving unit. The linen was not covered or stored, as per facility policy.</p> <p>4. It was observed on 5/24/2016 at 1:00 pm Neurology Testing Center off site clean linen store room, in the presence of #A27 (Neurology Testing Center Manager); assorted chemicals, dusty shipping cartons, etc were observed stored with the center's uncovered clean folded linen. Assorted chemicals were observed stored side-by-side with the clean linen. The linen was not covered or stored, as per facility policy.</p> <p>5. PolicyStat ID: 1315887, Linen/Bed Makeup Guideline, revised/reapproved</p>			

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 05/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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	<p>on 12/10/13 indicated on page 2:</p> <p>A. Linen taken into a patient's room is limited to the amount needed for patient care provided in that day only.</p> <p>B. All linen is considered contaminated once it is placed in a patient room.</p> <p>6. While on tour of facility on 5/24/16 at approximately 1530 hours, in the presence of staff N8 (Accreditation Coordinator), staff N18 (Registered Nurse [RN] Manager) confirmed linen stored in patient room cabinet is not replaced between patient room use.</p> <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.</p> <p>Based on document review, observation and interview, the hospital failed to enter</p>	S 1164	1. Review of Franciscan Alliance Preventive Maintenance Policy that stated, "The Clinical	07/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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
	<p>wheelchairs into equipment inventory and conduct annual preventive maintenance inspections on the walk-behind and riding floor scrubbers.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Franciscan Alliance Preventive Maintenance Policy that stated, "The Clinical Engineering Manager will maintain a current, accurate, unique inventory of all equipment included in the Equipment Management Plan. The manufacture's recommendations shall be followed to perform preventive maintenance." The policy was last approved 10/19/2015. 2. Review of the Whirlmatic walk-behind floor scrubber operator's manual stated, "Yearly maintenance schedule: Service drive motor brushes." 3. Review of the Advance Avenger riding floor scrubber operator's manual stated, "The yearly maintenance schedule: Check Carbon Brushes. Have Advance check the vacuum motor carbon motor brushes once a year or after 300 operating hours." 4. The Franciscan St. Francis Health Environmental Services Visual Equipment Check log reports lacked 		<p>Engineering Manager will maintain a current, accurate, unique inventory of all equipment included in the Equipment Management Plan. The manufacture's recommendations shall be followed to perform preventive maintenance." The policy was last approved 10/19/2015. 2. Review of the Whirlmatic walk-behind floor scrubber operator's manual stated, "Yearly maintenance schedule: Service drive motor brushes." This will be added to the equipment management plan for annual service 3. Review of the Advance Avenger riding floor scrubber operator's manual stated, "The yearly maintenance schedule: Check Carbon Brushes. Have Advance check the vacuum motor carbon motor brushes once a year or after 300 operating hours." This will be added to the equipment management plan for annual service 4. The Franciscan St. Francis Health Environmental Services Visual Equipment Check log reports lacked documentation of the required annual preventive maintenance inspections on the walk-behind and riding floor scrubbers. This will be added to the equipment management plan for annual service 5, 6, & 7. Control tags will be placed on all wheelchairs and added to the equipment management plan. Measurement of sustainability will be completed by adding metric to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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
	<p>documentation of the required annual preventive maintenance inspections on the walk-behind and riding floor scrubbers.</p> <p>5. It was observed on 5/24/2016 at 12:38 pm in the Sleep Center off site lobby, in the presence of #A29 (Sleep Center Manager); three wheelchairs were present without a control tag on the patient care equipment.</p> <p>6. It was observed on 5/24/2016 at 1:30 pm in the hospital lobby, in the presence of #A1 (Director of Patient Safety); five assorted wheelchairs were present without a control tag on the patient care equipment.</p> <p>7. At 2:15 PM on 5/24/2016, staff member #A20 (Clinical Engineer) indicated the wheelchairs are not part of the patient care equipment inventory log and the wheelchairs are not scheduled for routine preventive maintenance inspections. The staff member confirmed the required inventory of the hospital wheelchairs are not performed as per policy.</p> <p>8. At 9:30 AM on 5/25/2016, staff member #A12 (Engineering Supervisor) confirmed that the walk-behind and riding floor scrubbers annual preventive</p>		readiness/Safety rounding worksheets.	

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

PRINTED: 08/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
---	--	---	--

NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237
---	---

(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
	maintenance inspections were not performed as per manufacturer's recommendations..			