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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>150057 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/25/2012 |
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| S0000              | <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005052</p> <p>Survey Date: 4-23/25-12</p> <p>Surveyors:<br/>Jack I. Cohen, MHA<br/>Medical Surveyor</p> <p>John Lee, RN<br/>Public Health Nurse Surveyor</p> <p>Cleone Peterson<br/>Medical Surveyor</p> <p>QA: claughlin 05/01/12</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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| S0178  | <p>410 IAC 15-1.3-2<br/>POSTING OF LICENSE<br/>410 IAC 15-1.3-2(a)</p> <p>(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.</p> <p>Based on observation, the hospital failed to conspicuously post the hospital license in an area open to patients and the public.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 4-23-12 at 3:05 pm in the presence of employee #A7, it was observed the hospital posted its license adjacent to elevator 1, on the second floor inpatient unit.</li> <li>2. This area could only be viewed by patients and public entering the inpatient area. The vast majority of those people entering the hospital who had no reason to enter the inpatient area (to use various outpatient services, the Emergency Department and other hospital business) had no opportunity to observe the license.</li> </ol> | S0178   | <p>The license was moved to the front lobby on Tuesday, May 8, 2012. It was hung next to the Patient's Rights poster immediately on the left as you enter the main lobby.<br/>Responsible Person:<br/>Administrative Assistant</p> | 05/08/2012           |   |

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| S0554  | <p>410 IAC 15-1.5-2<br/>INFECTION CONTROL<br/>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 documentation review and interview, the hospital created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to employees.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of hospital Policy # 480.10, entitled CIDEX OPA, USE OF NON-GLUTERALDEHYDE HIGH LEVEL DISINFECTANT (HLD), last revised 4-12-11, indicated in Section V.E.1, Cidex OPA solution test strips will be used prior to each use to ensure the appropriate concentration of ortho-phthalaldehyde is present.</li> <li>On interview, on 4-23-12 at 3:10 pm, a hospital staff ultrasound technologist indicated if the Cidex was used more than once per day, he/she only checked it once per day and not prior to each usage.</li> <li>Review of documents entitled Cidex OPA Solution Log for the months of</li> </ol> | S0554   | <p>Infection Control Related to CIDEX</p> <p>Action Steps:</p> <p>The policy was reviewed by Quality Manager, Team Leader, and Director. After review it was determined the policy did not need updated but education to the staff was necessary. The policy was not being followed.</p> <p>Education to staff was provided via verbal, e-mail and written communication. Binders were placed in each US room that has CIDEX for reference.</p> <p>New CIDEX logs were created to allow staff multiple test results to be documented each day along with the daily initial check in the AM.</p> <p>The communication sent to all Ultrasound staff stated:</p> <p>"In order to be in compliance with the Franciscan St. Francis Hospital CIDEX policy and state regulations, please start implementing the following</p> | 05/02/2012   |  |   |  |

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|  | March, 2012 and April, 2012, indicated the test strips were used only once each day.                                   |   | <p>immediately:</p> <ol style="list-style-type: none"> <li>1) All CIDEX must be checked with a test strip every morning and documented on the CIDEX logs.</li> <li>2) Before each use, the CIDEX must be checked with a test strip and logged again on the log sheet.</li> </ol> <p>I have sent out new CIDEX logs, a copy of the hospital policy, CIDEX test strip log, and a copy of the MSDS for CIDEX. Please review the policy carefully.</p> <p>Thank you, Manager"</p> <p>This communication was sent via e-mail on May 4, 2012 with a return receipt requested.</p> <p>The CIDEX policy review will be included in the employee annual competency.</p> <p>Monitoring will be conducted on a random basis 15 times a quarter to ensure that CIDEX is checked daily by the US, team leader and manager. This monitoring activity will continue until six (6) consecutive months of compliance is obtained to assure process is hardwired with staff.</p> <p>Attachments: CIDEX OPA Test Strip Testing<br/>CIDEX Solution</p> |                      |   |

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|                          |  |                     | Log Sheet<br><br>Responsible Person: US Team<br>Leader and Imaging Manager   |                            |

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| S0608  | <p>410 IAC 15-1.5-2<br/>INFECTION CONTROL<br/>410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows:<br/>(3) The infection control committee responsibilities shall include, but not be limited to, the following:<br/>(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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on document review and observation, the facility failed to ensure that central sterile personnel follow established policy/procedure for appropriate attire for 1 soiled workroom.</p> <p>Findings include:</p> <p>1. Review of policy/procedure Infection Prevention Policy for Central Sterile Processing indicated the following:<br/>"2. Decontamination area:<br/>d. Safety glasses/glasses/face shield must be worn at all times while working in decontamination area."<br/>This policy/procedure was last reviewed/revised on 05-20-10.</p> | S0608   | <p>On April 24, 2012, we were cited for an employee in the dirty decontamination area that was not wearing the proper personal protection equipment. She was counseled on this issue on May 14, 2012. She has read the infection control policy and understands that she will be spot checked for the next month to check compliance with the policy. Monthly audits will be done to ensure that all employees are wearing their personal protection equipment.</p> <p>A monthly audit of ten spot checks will be conducted until six (6) consecutive months of compliance is obtained to assure process is hardwired with staff.</p> | 05/14/2012   |  |   |  |

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|  | 2. On 04-24-12 at 1020 hours during the facility tour of the soiled workroom/decontamination area staff #46 was observed to be gross cleaning equipment and wearing eye glasses low on his/her nose causing the eyes to be potentially exposed to biological matter. |   | Attachments: PPE Audit Sheet<br>Counseling Memo<br><br>Responsible Person: OR<br>Manager                        |                      |   |

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| S0868  | <p>410 IAC 15-1.5-5<br/>MEDICAL STAFF<br/>410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:<br/>(3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed:<br/>(i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff;<br/>(ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or<br/>(iii) within forty-eight (48) hours after an admission.</p> <p>Based on document review, the facility failed to ensure that a complete physical examination and medical history was performed on each patient admitted by a practitioner who has been granted such privileges by the medical staff within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission and or within forty-eight (48) hours after an admission for 2 of 13 inpatient medical records (MR) reviewed (Patient #2 &amp; 19).</p> | S0868   | <p>Education will be provided to the surgeons about the requirements for the History and Physical. The attached PowerPoint will be reviewed at both the Orthopedic Section meeting and the Surgeons Section meeting. The Clinical Services Director will be providing this education at the Orthopedic Section meeting on Tuesday, May 15, 2012 and the Surgeons Section meeting on Thursday, May 17, 2012.</p> <p>Random monthly audits will be completed to show the compliance rate of the History and Physicals being completed</p> | 05/17/2012   |  |   |  |

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|  | <p>Findings include:</p> <p>1. Review of patient #2's MR indicated the patient was admitted to the facility on 04-24-12 and the history and physical was done on 04-09-12 and the update to the history and physical was done on 04-23-12 at 1234 hours.</p> <p>2. Review of patient #19's MR indicated the patient was admitted to the facility on 03-19-12 and the history and physical was done on 02-16-12 and the update to the history and physical was done on 03-08-12.</p> |   | <p>timely. Using the attached spreadsheet we will monitor ongoing compliance and be able to identify and educate the specific physicians who do not comply. Data will be provided to the Medical Staff Performance Improvement Committee. This data will be audited and compiled monthly by the Manager of Health Information Management.</p> <p>All education will be provided by May 17, 2012. At the beginning of every month, charts from the previous month will be reviewed and ongoing education provided as needed. These reports will be submitted to the Medical Staff Performance Improvement Committee.</p> <p>Attachments: H&amp;P Documentation Requirements PowerPoint, and Audit Tool for H&amp;P</p> <p>Responsible Person: Manager of Health Information Management</p> |                      |   |

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| S0912  | <p>410 IAC 15-1.5-6<br/>NURSING SERVICE<br/>410 IAC 15-15-6 (a)(2)(B)(i)(ii)<br/>(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is:<br/>(B) responsible for the following:<br/>(i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital.<br/>(ii) Maintaining a current nursing service organization chart.<br/>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.<br/>(iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements.<br/>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review, the facility failed to ensure that nursing personnel follow established policy/procedure for nursing care for 2 of 2 obstetrical medical records (MR) reviewed (Patient #12 &amp;</p> | S0912   | The following actions have been/are being taken to correct deficiencies noted by the ISDOH Survey on April 25, 2012: Immediate review of policies 460.80; Standard title: Obstetrics | 06/01/2012   |  |   |  |

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|  | <p>13).</p> <p>Findings include:</p> <p>1. Review of policy/procedure 460.80, Obstetrics - Postdelivery/Postpartum, indicated the following:<br/>"Nursing Practice Guidelines (post-Delivery - Specific)<br/>1. RN to perform the initial patient patient assessment as follows:<br/>b. second hour post delivery: every 30 minutes (x two)<br/>Assessment to include:<br/>a. Vital signs: Blood pressure, heart rate and respirations.<br/>b. Uterus / Fundus for firmness, height, position and tenderness.<br/>c. Bleeding for amount, color and presence of clots.<br/>d. Perineum:<br/>i. Episotomy, lacerations and hemorrhoids.<br/>ii. Bruising, hematoma, edema, discharge and loss of approximatone."<br/>This policy/procedure was last reviewed/revised on 02-08-11.</p> <p>2. Review of patient #12's MR indicated the patient delivered a baby on 03-13-12 at 1613 hours and the MR lacked documentation that the second hour postdelivery assessments were done.</p> |   | <p>- Post-delivery/Postpartum and 460.67 Care of the Postpartum Patient was performed on April 26, 2012. Inconsistent and conflicting information was identified in the policies. Frequency of assessments was discussed with staff by the Nursing Manager during staff meeting on April 30, 2012. Policies will be reviewed and revised by June 12, 2012 at the next Clinical Practice Council meeting with correct information provided referencing frequency of assessments. Education will be provided in PowerPoint format to staff by July 3, 2012 regarding frequency of assessments. Unit manager and educator will provide this education. An assessment pocket card with frequency of assessments reminders will be developed and provided to staff by July 3, 2012. This will be done by the Unit Council and reviewed by the manager and educator. A chart audit tool has been developed and will be utilized to monitor compliance with policy. Audits will be done by management team monthly with results shared with staff. Monitoring will continue until six (6) consecutive months of compliance is obtained to assure process is hardwired with all staff. Attachment: Post Delivery Assessment Audit Tool<br/>Responsible Person: Obstetrics Manager</p> |                      |   |

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|  | 3. Review of patient #13's MR indicated the patient delivered a baby on 03-13-12 at 0930 hours and the MR lacked documentation that the second hour postdelivery assessments were done. |   |   |                      |   |

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| S0932  | <p>410 IAC 15-1.5-6<br/>NURSING SERVICE<br/>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, the facility failed to ensure that the nursing staff developed and utilized an ongoing individualized plan of care based on standards of care for each patient for 3 of 10 care plans reviewed (Patient #4, 17 and 19).</p> <p>Findings include:</p> <p>1. Review of policy/procedure 400.15, Plan of Care, indicated the following:<br/>"VI. Procedure:<br/>A. Initiating the Nursing Plan of Care (to be performed by the RN)<br/>3. Develop the plan of care (must be initiated within 8 hours of admission).<br/>B. Shift Review<br/>2. At the beginning of every shift, the oncoming RN must officially document that the Care Plan was reviewed."<br/>This policy/procedure was last reviewed/revised on 02-08-11.</p> <p>2. Review of patient #4's medical record</p> | S0932   | <p>1. Education for nursing staff on the Inpatient Units related to Nursing Plan of Care deficiencies will be completed by May 27, 2012 and will be a required activity for all patient caregivers on the inpatient units.</p> <p>2. Management will be responsible to audit 10% of patient admissions to their respective units to validate completeness and accuracy of Plan of Care to the end of the year. The goal is improvement in documentation. This audit will continue until six (6) consecutive months of compliance is obtained to assure process is hardwired with all staff.</p> <p>Attachment: Nursing Plan of Care Audit Tool</p> <p>Responsible Person: Nursing Unit Managers</p> | 05/27/2012           |   |

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|  | <p>(MR) indicated the patient was admitted to the facility on 12-09-11 and was discharged on 12-15-11. Patient #4's MR lacked documentation that the Care Plan was reviewed by a RN from 12-10-11 at 0143 hours to 12-11-11 at 2054 hours. Patient #4's MR lacked documentation that the Care Plan was reviewed by a RN from 12-12-11 at 0328 hours to 12-14-11 at 1518 hours. Patient #4's MR lacked documentation that the Care Plan was reviewed by a RN from 12-14-11 at 1518 hours to 12-15-11 at 0732 hours.</p> <p>3. Review of patient #17's MR indicated the patient was admitted to the facility on 03-09-12 at 1025 hours and was discharged on 03-17-12 at 1517 hours. Patient #17's MR indicated the Care Plan was started on 03-13-12 at 1604 hours. Patient #17's lacked documentation that the Care Plan was reviewed by a RN from 03-13-12 at 2054 hours to 03-15-12 at 0201 hours. Patient #17's lacked documentation that the Care Plan was reviewed by a RN from 03-15-12 at 0201 hours to 03-16-12 at 0505 hours.</p> <p>4. Review of patient #19's MR indicated the patient was admitted to the facility on 03-13-12 at 0947 hours and was discharged on 03-16-12 at 1059 hours. Patient #19's MR indicated the Care Plan was started on 03-13-12 at 0656 hours.</p> |   |   |  |  |   |  |

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|  | Patient #19's lacked documentation that the Care Plan was reviewed by a RN from 03-14-12 at 1851 hours to 03-15-12 at 1639 hours. Patient #17's lacked documentation that the Care Plan was reviewed by a RN from 03-15-12 at 1639 hours to 03-16-12 at 0949 hours. |   |   |                      |   |

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| S1118  | <p>410 IAC 15-1.5-8<br/>PHYSICAL PLANT<br/>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 created a condition which resulted in a hazard to employees in 1 instance.</p> <p>Findings:</p> <p>1. Review of hospital Policy No. 941.07, entitled SAFE HANDLING AND STORAGE OF COMPRESSED GAS CYLINDERS, indicated storage of gas cylinders will be in containers built for that purpose, securing the bottom and upper half of the cylinder.</p> <p>2. On 4-23-12 at 2:55 pm in the presence of employee #A7, it was observed in a Heating, Ventilation and Cooling (HVAC) area there was a fire extinguisher (compressed gas cylinder) on the floor, unsecured by chain, holder or container.</p> | S1118   | <p>ID Prefix Tag S1118 Maintenance was being done by Maintenance staff and the fire extinguisher was moved to facilitate use during the process if needed in an emergency. The fire extinguisher was hung back on the wall on a hook on April 23, 2012, the same day as the observation by the ISDOH surveyor. Responsible Person: Director of Facilities<br/>Date of Completion: April 23, 2012</p> | 04/25/2012   |  |   |  |

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|                    | 3. If the extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property. |               |   |                      |

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| S1150  | <p>410 IAC 15-1.5-8<br/>PHYSICAL PLANT<br/>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> <p>1. On 4-23-12 at 12:10 pm in the presence of employee #A7, it was observed in the Radiation Therapy darkroom there was a flexible hose connected to a water spigot without a backflow prevention device.</p> <p>2. On 4-23-12 at 2:15 pm in the presence of employee #A7, it was observed in the Laundry Room there was a flexible hose connected to a water line without a backflow prevention device.</p> | S1150   | <p>The flexible hose was removed in the Radiation Therapy room. This was done April 23, 2012.</p> <p>Laundry backflow prevention was put in place on April 25, 2012 and was certified as functional on April 25, 2012 per state requirements.</p> <p>Responsible Person: Director of Facilities</p> | 04/25/2012   |  |   |  |

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| S1168  | <p>410 IAC 15-1.5-8<br/>PHYSICAL PLANT<br/>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 observation and document review, the facility failed to ensure that defibrillators were discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained for 3 of 5 patient care unit toured (Emergency Department, Surgery Department and Obstetrical Unit).</p> <p>Findings include:</p> <p>1. Review of the manufacturer's recommendations for the Philips defibrillator indicated the following:<br/>"Weekly Shock Test<br/>In addition to the shift check, you must verify the ability to deliver defibrillation therapy once a week by performing one of the following:<br/>- Operational Check<br/>- Weekly Shock Test"</p> <p>2. Review of policy/procedure 400.60,</p> | S1168   | <p>1. Staff will be provided education on the proper completion of the crash cart/defibrillator log by June 1, 2012.</p> <p>2. Managers from the Surgery, Obstetrics and Emergency Departments will audit defibrillator logs each week for six (6) months to assure staff understanding of correct use and necessity of proper checking of their respective defibrillator(s).</p> <p>3. Management will continue to monitor unit defibrillator logs until six (6) consecutive months of compliance is obtained to assure process is hardwired with all staff.</p> <p>Attachment: Crash Cart/Defibrillator Log</p> <p>Responsible Persons: Nursing</p> | 06/01/2012   |  |   |  |

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|  | <p>Code Blue, indicated the following on page 4:</p> <p>"G. Maintaining, Restocking and Securing Code Cart and Emergency Equipment / Supplies</p> <p>2. Daily Code Cart, Emergency Equipment / AED / Defibrillator Check</p> <p>d) Defibrillators will be checked per the manufacturer's recommendations specific to the model / type of equipment."</p> <p>This policy/procedure was last reviewed/revised on 04-14-10.</p> <p>3. During the facility tour of the Emergency Department on 04-23-12, of the Surgery Department on 04-24-12 and the Obstetrical Inpatient Unit on 04-24-12, a Philips defibrillator was observed in each area.</p> <p>4. Review of the Emergency Department Defibrillator Discharge Log indicated the Philips Defibrillator was discharged on 02-14-12, 02-28-12, 03-01-12, 03-08-12, 04-01-12 and 04-14-12. The Defibrillator Discharge log indicated that the defibrillator was not discharged 6 of 15 opportunities.</p> <p>5. Review of the Surgery Department Defibrillator Discharge Log indicated that the defibrillator was not discharged 15 of 15 opportunities.</p> |   | Managers of Surgery, Obstetrics and Emergency Departments   |  |  |   |  |

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|  | 6. Review of the Obstetrical Inpatient Unit Defibrillator Discharge Log indicated the Philips Defibrillator was discharged on 02-08-12, 02-15-12, 03-01-12, 03-08-12, 03-15-12, 03-22-12 and 03-29-12. The Defibrillator Discharge log indicated that the defibrillator was not discharged 7 of 15 opportunities. |  |  |  |
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| S1186  | <p>410 IAC 15-1.5-8<br/>PHYSICAL PLANT<br/>410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E)<br/>(i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following:<br/>(3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety.<br/>(B) Health care worker safety.<br/>(C) Public and visitor safety.<br/>(D) Hazardous materials and wastes management in accordance with federal and state rules.<br/>(E) A written fire control plan that contains provisions for the following:<br/>(i) Prompt reporting of fires.<br/>(ii) Extinguishing of fires.<br/>(ii) Protection of patients, personnel, and guests.<br/>(iv) Evacuation.<br/>(v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to follow its fire control plan to conduct fire drills in 2 instances.</p> <p>Findings:</p> <p>1. Review of a document entitled MANAGEMENT PLAN FOR EMERGENCY PREPAREDNESS -2011, approved 1-28-11, indicated in Section V., the staff's knowledge of the Emergency Preparedness Plan is tested during monthly fire drills.</p> | S1186   | <p>On May 16, 2012, fire drills were conducted at the Cancer Center. On May 17, 2012, fire drills were conducted at the Central Warehouse offsite. These two sites have been added to the schedule so that quarterly fire drills are performed. Responsible Person: Security Supervisor</p> | 05/16/2012   |  |   |  |

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|                    | <p>2. Review of facility fire drills indicated there was only 1 fire drill each performed in calendar year 2011 at the Cancer Center offsite (June 3) and the Central Warehouse offsite (June 30).</p> <p>3. On interview, on 4-25-12 at 3:20 pm, employee #A6 indicated there were no other fire drills performed at the above offsites in year 2011 and no further documentation was provided prior to exit.</p> |               |   |                      |

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| S2120  | <p>410 IAC 15-1.6-8<br/>SURGICAL SERVICES<br/>410 IAC 15-1.6-8 (c)(2)</p> <p>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:</p> <p>(2) There shall be a history and physical workup in the chart of every patient prior to surgery, except in emergencies. If this has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting physician, which includes vital signs, allergies, and appropriate data.</p> <p>Based on document review the facility ensure that there be a history and physical workup in the chart of every patient prior to surgery, except in emergencies for 1 of 5 surgery medical records (MR) reviewed (Patient #20).</p> <p>Findings include:</p> <p>1. Review of patient #20's MR indicated that the the patient was in surgery on 03-15-12 from 1300 hours to 1515 hours. The history and physical was documented as being done on 03-15-12 at 1343 hours. Patient #20's MR lacked documentation that this surgery was an emergency.</p> | S2120   | <p>Education will be provided to the surgeons about the requirements for the History and Physical. The attached PowerPoint will be reviewed at both the Orthopedic Section meeting and the Surgeons Section meeting. The Clinical Services Director will be providing this education at the Orthopedic Section meeting on Tuesday, May 15, 2012 and the Surgeons Section meeting on Thursday, May 17, 2012.</p> <p>Random monthly audits will be completed to show the compliance rate of the History and Physicals being completed timely. Using the attached spreadsheet we will monitor</p> | 05/17/2012   |  |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>FRANCISCAN ST FRANCIS HEALTH - MOORESVILLE |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1201 HADLEY RD<br>MOORESVILLE, IN 46158   |                      |   |
| (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>ongoing compliance and be able to identify and educate the specific physicians who do not comply. Data will be provided to the Medical Staff Performance Improvement Committee. This data will be audited and compiled monthly by the Manager of Health Information Management.</p> <p>All education will be provided by May 17, 2012. At the beginning of every month, charts from the previous month will be reviewed and ongoing education provided as needed. These reports will be submitted to the Medical Staff Performance Improvement Committee.</p> <p>Attachments: H&amp;P Documentation Requirements PowerPoint, and Audit Tool for H&amp;P</p> <p>Responsible Person: Manager of Health Information Management</p> |                      |   |