

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/10/2014
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 12188 B NORTH MERIDIAN STREET CARMEL, IN 46032
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 12/9/2014 through 12/10/2014</p> <p>Facility Number: 012826</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 01/22/15</p>	S000000		
S000554	<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>			

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>Based on documentation review, observation and staff interview, the hospital failed to ensure 2 of 3 Operating Rooms were maintained at the minimum required temperature of 68 degrees Fahrenheit as per hospital policies and procedures, failed to wash their hands before working in the kitchen and failed to ensure a safe environment for patients by ensuring clean supplies and equipment were protected from contamination.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Franciscan St. Francis - Carmel 2014 Infection Control Plan approved Association for Operating Room Nurses (AORN) as infection control guidelines for the hospital. AORN supports the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on temperature and humidity ranges for perioperative settings. The Operating Rooms temperature 	S000554	<p>S554 2 - Engineering personnel will monitor OR temperatures on a daily basis. Engineering personnel will be notified by electronic monitoring if the OR temperature is less than 68 or greater than 73 degrees. If the OR temperature reading is outside these ranges, the Engineering personnel will contact the OR personnel to ascertain the reason for the out of range temperatures to confer that there is a clinical need for the temperature variation. If the temperature variation is out of range without clinical need, Engineering personnel will investigate the cause.</p> <p>Responsible Person: Engineering Personnel On Site S554 - 3. Due to bulky, multiple layers of clothing worn by physicians performing operations, some physicians desire that operating room temperature be set below the ASHRAE recommended guidelines. The deviation from recommended design temperatures shall be reflected in the attached Infection Prevention Policy – Infection Prevention Policy for Engineering by adding the following new line item: III.B.2.f. The operating room will be monitored daily; temperature is to be maintained between 68 to 73 degrees Fahrenheit and the relative humidity is to be maintained between 20% and 60%. Unique circumstances may require</p>	02/05/2015			

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	<p>range should be between 68 F and 73 F.</p> <p>3. Staff member #28 (Biomedical Engineer) provided Franciscan St. Francis Hospital: Carmel OR Temps and Humid Trend computer generated reports for 12/1/2014 through 12/7/2014. The report evidenced Operating Room #2 temperature averaged approximately 63 degrees Fahrenheit. The report evidenced Operating Room #3 temperature averaged approximately 65 degrees Fahrenheit.</p> <p>4. At 1:00 PM on 12/10/2014, staff member #3 (Nurse Manager) indicated the hospital follows the AORN guidelines as it relates to infection control practices.</p> <p>5. Franciscan St. Francis Health - Carmel Food & Nutrition Services Department Policies and Procedure Manual (last approved 3/2012) indicated the hospital shall comply with The Retail Food</p>		<p>variations in the operating room to be outside of these recommended ranges. If the temperature is out of range, engineering will confer and confirm with the operating room staff that there is a clinical need for this variation and document accordingly. (See attachment A Infection Prevention Policy.) The Director of Infection Control is responsible for implementing the policy modification and will obtain formal approval of the policy modification from the Infection Control Committee at the next meeting scheduled for March 19, 2015. Engineering department personnel will monitor operating room temperature on a daily basis and will be notified by the electronic monitor when temperature is <68 or >73. If the temperature is out of range, engineering will confer and confirm with the operating room staff that there is a clinical need for this variation and document accordingly. Variations without clinical need will be investigated and corrective action will occur. Completion Date: 2-5-15S554 - 7aStaff will be trained to use the sink outside of the kitchen for handwashing should there be a problem with the kitchen sink. Staff will be informed to leave the door open if the handwashing sink is not operational. This information was provided to staff in a powerpoint presentation (Attachment B) distributed to all</p>		

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	<p>Establishment Sanitation Requirements, Title 410 IAC 7-24.</p> <p>6. Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24 (Effective Date November 13, 2014) indicated food employees shall clean their hands and exposed portions of their arms before engaging in food preparation, including working with exposed food, clean equipment and utensils, unwrapped single-service and single-use articles; before placing gloves on hands. A food service worker shall used sanitizer in lieu of hand washing.</p> <p>7. At 10:30 AM on 12/9/2014, the hospital kitchen was toured. The only hand sink in the kitchen was observed without any faucet handles. A staff member in the kitchen was observed changing gloves multiple times without washing his/her hands.</p> <p>8. At 11:00 AM on 12/9/2014,</p>		<p>staff preparing food for patients. This was specifically addressed on page 5 of the powerpoint presentation noting what to do if hand washing sink is not operational. (see page 5 of the attached powerpoint presentation – attachment B.) The faulty faucet for the sink located in the kitchen was replaced with a new faucet and the sink returned to service on December 9, 2014. (See attachment C - Engineering Work Order #483325 documenting the repair.) The sink should not have been taken out of service until the parts were available to make repairs or temporary arrangements made to provide alternate means for employees to wash their hands. The Director of Engineering will be responsible for reviewing with Engineering staff the Infection Prevention Policy for Engineering at the next department meeting scheduled for February 19, 2015. Responsible Persons: Director of Food and Nutrition Services - CIR Director of Engineering Completion Date: 12-30-14, 12-9-14, 2-19-15S554 7b: All staff who prepare food for patients will be retrained on proper hand washing techniques. A powerpoint presentation was prepared for all staff and distributed via e-mail. The powerpoint presentation provided information (see page 5 of attached powerpoint – Item B) on when gloves must be changed or</p>		

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	<p>staff member #19 (In-patient PCC) indicated he/she walked out of a patient's room and used the hand sanitizer that was mounted on the hallway wall before entering into the kitchen followed by putting on latex gloves.</p> <p>9. Staff member #19 confirmed at 11:00 AM on 12/9/2014 that he/she used the hand sanitizer and did not wash his/her hands before working in the kitchen. 10. During the tour of the in-patient unit at 1:10 PM on 12/09/14, accompanied by staff members #6, the Quality Manager, and #19, the Patient Care Coordinator, some outside shipping boxes were observed stored on shelves along with unpackaged, clean supplies.</p> <p>11. At 3:25 PM on 12/09/14, the Delivery Office was inspected with staff members #1, the Director of Operations, and #2, the HVAC Mechanic. Approximately ten large outside shipping boxes were observed broken down and leaning against unpackaged, clean supplies on an open, metal rack. The boxes were in close proximity to unpackaged suction canisters and lids. On the other side of the room, some</p>		<p>removed. Also included in the powerpoint presentation (see page 4 of attached powerpoint – Item B) is information on when to wash hands, use of gloves, and how to wash hands. See page 3 of the attached powerpoint where staff received information on how to wash hands and that hand sanitizer is not permitted as a replacement for hand washing. Responsible Person: Director of Food and Nutrition Services – CIR Completion Date - 12/30/14S554 - 8All staff who prepare food for patients will be retrained on proper hand washing techniques. A powerpoint presentation was prepared for all staff and distributed via e-mail. The powerpoint presentation provided information (see page 5 of attached powerpoint – Item B) on when gloves must be changed or removed. Also included in the powerpoint presentation (see page 4 of attached powerpoint – Item B) is information on when to wash hands, use of gloves, and how to wash hands. See page 3 of the attached powerpoint where staff received information on how to wash hands and that hand sanitizer is not permitted as a replacement for hand washing. Responsible Person: Director of Food and Nutrition Services – CIR Completion Date: 12-30-14S554 - 9All staff who prepare food for patients will be retrained on proper hand washing techniques. A powerpoint</p>		

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	<p>outside shipping boxes of supplies were on the shelving unit along side small, unwrapped packages of patient supplies.</p> <p>12. At 3:30 PM on 12/09/14, both staff members #1 and #2 confirmed the unpackaged supplies were overflow items that were normally stored on the units. They also confirmed the suction canisters and lids appeared to be the ones that were used in the patient rooms and surgical suites.</p>		<p>presentation was prepared for all staff and distributed via e-mail. The powerpoint presentation provided information (see page 5 of attached powerpoint – Item B) on when gloves must be changed or removed. Also included in the powerpoint presentation (see page 4 of attached powerpoint – Item B) is information on when to wash hands, use of gloves, and how to wash hands. See page 3 of the attached powerpoint (item B) where staff received information on how to wash hands and that hand sanitizer is not permitted as a replacement for hand washing. Responsible Person: Director of Food and Nutrition Services – CIR Completion Date: 12-30-14 <u>S554, # 10</u> 1. Two outside shipping boxes were found in the Medical Supply room that were still in cardboard shipping boxes. These boxes have been removed from the Inpatient Medical Supply Storage Room as of 2/2/15. An email was sent to all inpatient unit staff on 1-31-15 informing them of the need to adhere to this practice. Going forward, all medical supplies will be removed from outside shipping boxes prior to being placed on the supply shelves. (See attached email reminder sent to Inpatient Unit staff on 1/31/15 – Item D). 2. Bi-Weekly inspection of the medical supply room will be performed to validate ongoing</p>				

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			<p>compliance with this requirement. The Patient Care Coordinator of the Inpatient Unit and the facility Materials Coordinator will be responsible for maintaining compliance with this requirement and correcting any deficiencies. Responsible Parties: Patient Care Coordinator Inpatient Unit Facilities Materials Coordinator Completion Date: 2-2-15S554 - 11. The outside shipping boxes found leaning against unpackaged, clean supplies and in close proximity to unpackaged suction canisters and the outside shipping boxes located on a shelving unit alongside small unwrapped packages of patient supplies were removed from area on December 9, 2014. (See attachment E - Engineering Work Order #483317 documenting corrective action.) Since Engineering Department personnel are responsible for receiving and storing supplies at the Carmel Hospital, the Director of Engineering will be responsible for reviewing and documenting the review of the proper infection control procedures for material handling at the next Engineering Department Meeting scheduled for February 19, 2015. Responsible Party: Director of Engineering Completion Date: 12-9-14, 2-19-15S554 - 12S 554 12. Supplies in shipping boxes were segregated from supplies in product boxes on December 9, 2014. (See attachment F -</p>	

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on documentation review, observation and staff interview, the infection control committee failed</p>	S000596	<p>Engineering Work Order #483319) documenting the corrective action. Since Engineering Department personnel are responsible for receiving and storing supplies at the Carmel Hospital, the Director of Engineering will be responsible for reviewing and documenting the review of proper infection control practices for material handling at the Engineering Department Meeting scheduled for February 19, 2015. Responsible Party: Director of Engineering Completion Date 12-9-14, 2-19-15</p> <p>S596 – 1</p> <p>Ultrasound will implement rinsing of device with three separate rinses, with each rinse being a minimum of</p>	02/09/2015	

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	<p>to ensure chemical Cidex OPA was used accordingly to the manufacturer's recommendations and hospital policies in the Radiology Department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Cidex OPA, Use of Non-Gluterldehyde High Level Disinfectant (HLD) policy (last revised 6/10/2014) rinsing instructions indicated all devices immersion in Cidex OPA solution, thoroughly rinse the device by immersing it completely in a large volume of sterile water. This process will be repeated twice with sterile water. Each rinse should be a minimum of one minute in duration. 2. The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for semi-critical devices. Cidex OPA manufacturer sheet requires: Manual rinsing procedure - thoroughly rinse the 		<p>one minute in duration. Will review full policy with Ultrasound staff.</p> <p>All plans of correction will be implemented. Staff will be informed and documentation of review with staff will be maintained in the employee record. Periodic audits for compliance will be held quarterly and reported on the department quality dashboard.</p> <p>Responsible Person: Ultrasound Supervisor S596 – 2</p> <p>Ultrasound will implement rinsing of device with three separate rinses, with each rinse being a minimum of one minute in duration. Will review full policy with Ultrasound staff. Ultrasound staff will wear PPE of (goggles, gloves, and fluid resistant gowns) when handling Cidex OPA.</p> <p>All plans of correction will be implemented. Staff will be informed and documentation of review with staff will be maintained in the employee record. Periodic audits for compliance will be held quarterly and reported on the department quality dashboard.</p> <p>Responsible Person: Ultrasound Supervisor S596 – 3</p> <p>Ultrasound staff will implement</p>				

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	<p>semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done. Cidex OPA manufacturer sheet requires use PPE when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns.</p> <p>3. At 12:14 PM on 12/9/2014, the Ultrasound room of the Radiology Department was inspected. The room contained a wall mounted ventilating system for Cidex OPA. The system contained two 32-ounce containers. One container was three-quarters filled with Cidex OPA and the other container was three-quarters filled with water. The label on the exterior of the container filled with water stated, "Rinse probe in this container 30 seconds." The room was observed without any aprons.</p> <p>4. At 12:20 PM on 12/9/2014,</p>		<p>rinsing of device with three separate rinses, with each rinse being a minimum of one minute in duration. Will change labeling of container to indicate new procedure of three separate rinses, with a minimum of one minute each.</p> <p>All plans of correction will be implemented. Staff will be informed and documentation of review with staff will be maintained in the employee record. Periodic audits for compliance will be held quarterly and reported on the department quality dashboard.</p> <p>Responsible Person: Ultrasound Supervisor S596 – 4</p> <p>Ultrasound will implement rinsing of device with three separate rinses, with each rinse being a minimum of one minute in duration. Will review full policy with Ultrasound staff. Staff will also comply with use of PPE (goggles, gloves and fluid resistant gowns) when handling Cidex OPA.</p> <p>All plans of correction will be implemented. Staff will be informed and documentation of review with staff will be maintained in the employee record. Periodic audits for compliance will be held quarterly and reported on the department quality dashboard.</p>		

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	<p>failed to ensure the surgical staff followed their dress code policy regarding surgical masks in three (3) instances.</p> <p>Findings included:</p> <p>1. The facility's policy "Dress Code for Surgery, Surgery Support Areas, Labor and Delivery, Cardiac and Vascular Labs", last reviewed 10/2011, indicated, "7. All persons shall wear a disposable mask while opening sterile supplies and during a procedure, ...Masks must be disposed of when leaving the sterile area." The policy referenced "AORN Standards, Recommended Practices, and Guidelines, 2010 Edition."</p> <p>2. During the tour of the surgical department at 12:05 PM on 12/09/14, accompanied by staff member #6, the Quality Manager of Surgery/Anesthesia, the following observations were made:</p> <p>A. A female staff member with a surgical mask hanging around her neck, came out of the break room, used the restroom, and returned to the breakroom.</p> <p>B. A male staff member was at the bedside of a patient in the recovery room with a surgical mask hanging around his neck on the back of his scrub top.</p> <p>C. A male staff member was on the computer in the recovery area with a</p>		<p>1. All O.R. staff received a written memo on 1-31-15 via e-mail regarding the requirement of removing masks upon exiting the O.R. (See attachment G e-mail.) Our Medical Staff, including surgeons, anesthesia and first assists received the same memo via e-mail. This memo reminds staff that they must remove surgical masks upon exiting the OR at the end of each case. In this memo, staff were reminded that masks are intended for single use only and should be disposed of upon leaving the sterile area. Vendors will be reminded of this requirement as well. Furthermore signage reminders will be placed in each OR outlining this requirement (see attachment H signage.)</p> <p>2. Continuous peer to peer monitoring for compliance will be conducted with all staff being responsible for reminding one another if non-compliance is noted. Responsible Person:</p>				

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	<p>surgical mask hanging around his neck on the front of the scrub top, with the top strings still tied to be pulled back up.</p> <p>3. At 1:00 PM on 12/09/14, staff member #6 confirmed the facility followed AORN guidelines which also indicated surgical masks should be removed at the completion of each case and not worn around the neck.</p> <p>4. At 1:10 PM on 12/10/14, staff member #3, the Manager of Nursing Practice, indicated the Dress Code policy just went to committee for review today.</p>		<p>Patient Care Coordinator of the OR Director of Operations</p> <p>1. All O.R. staff received a written memo on 1-31-15 via e-mail regarding the requirement of removing masks upon exiting the O.R. (See attachment G e-mail.) Our Medical Staff, including surgeons, anesthesia and first assists received the same memo via e-mail. This memo reminds staff that they must remove surgical masks upon exiting the OR at the end of each case. In this memo, staff were reminded that masks are intended for single use only and should be disposed of upon leaving the sterile area. Vendors will be reminded of this requirement as well. Furthermore signage reminders will be placed in each OR outlining this requirement (see attachment H signage.)</p> <p>2. Continuous peer to peer monitoring for compliance will be conducted with all staff being responsible for reminding one another if</p>		

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			<p>non-compliance is noted.</p> <p>Responsible Person: Patient Care Coordinator of the OR Director of Operations</p> <p><u>S 608, # 2c</u></p> <p>1. All O.R. staff received a written memo on 1-31-15 via e-mail regarding the requirement of removing masks upon exiting the O.R. (See attachment G e-mail.) Our Medical Staff, including surgeons, anesthesia and first assists received the same memo via e-mail. This memo reminds staff that they must remove surgical masks upon exiting the OR at the end of each case. In this memo, staff were reminded that masks are intended for single use only and should be disposed of upon leaving the sterile area. Vendors will be reminded of this requirement as well. Furthermore signage reminders will be placed in each OR outlining this requirement (see attachment H signage.)</p> <p>2. Continuous peer to peer monitoring for compliance will be</p>		

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			<p>conducted with all staff being responsible for reminding one another if non-compliance is noted. Responsible Person: Patient Care Coordinator of the OR Director of Operations S 608, # 3</p> <p>1. All O.R. staff received a written memo on 1-31-15 via e-mail regarding the requirement of removing masks upon exiting the O.R. (See attachment G e-mail.) Our Medical Staff, including surgeons, anesthesia and first assists received the same memo via e-mail. This memo reminds staff that they must remove surgical masks upon exiting the OR at the end of each case. In this memo, staff were reminded that masks are intended for single use only and should be disposed of upon leaving the sterile area. Vendors will be reminded of this requirement as well. Furthermore signage reminders will be placed in each OR outlining this requirement (see</p>	

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S000610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition</p>		<p>attachment H signage.) 2. Continuous peer to peer monitoring for compliance will be conducted with all staff being responsible for reminding one another if non-compliance is noted. Responsible Person: Patient Care Coordinator of the OR Director of Operations <u>S 608, # 2b</u></p>				

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	<p>refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on documentation review and observation, the infection control committee failed to ensure the Dietary Department was complying with hospital policy and basic temperature requirements in 410 IAC 7-24, Retail Food Establishment Sanitation Requirements effective November 13, 2004.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Franciscan St. Francis Health - Carmel Food & Nutrition Services Department Policies and Procedure Manual (last approved 3/2012) indicated the hospital shall comply with The Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24. 2. Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24 (Effective Date November 13, 2014) indicated 	S000610	<p>610-3</p> <p>Staff were retrained via distribution of powerpoint presentation on the retherming rather than cooking of foods. Staff were retrained that food must be at least 165 degrees for 15 seconds per state regulation. Per Mr. Daeger's suggestion, we also trained staff to reheat to at least 170 degrees to simplify the reheating procedures. This information was included in the powerpoint presentation on page 10. Page 9 of the powerpoint presentation provided information on when to calibrate thermometers and critical control temperatures. (See attachment B - powerpoint presentation.)</p> <p>Responsible Parties: Director of Food and Nutrition Services – CIR</p>	12/30/2014	

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S000912	<p>potentially hazardous food that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least one hundred sixty-five (165) degrees Fahrenheit for fifteen (15) seconds.</p> <p>3. At 10:30 AM on 12/9/2014, staff member #19 (In-patient PCC) was observed reheating fully cooked pot roast in an industrial microwave and it was served to a patient. The internal temperature of the pot roast was 162 degrees Fahrenheit at time of removal from microwave.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (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>			
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	<p>(2) A nurse executive who is: (B) responsible for the following: (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. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (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. (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 policy and procedure review, medical record review, and interview, the nurse executive failed to ensure pain assessments were done according to policy and protocol for 5 of 6 patients whose postop documentation was reviewed (#13, #14, #15, #16 and #18).</p> <p>Findings included:</p> <p>1. Review of the facility policy "Assessment of Pain", last revised 06/12/2012, indicated, "3. Reassessment of Pain in one (1) hour: a. After</p>	S000912	S 912, #3 1. This deficiency is primarily one of failure to perform the appropriate documentation in the electronic medical record regarding the documentation of the required pain assessment and documenting in a timely manner that the pain assessment was done. Staff were informed of this documentation concern via e-mail reminding staff that any intervention for pain must be followed in an hour with a post-interventional assessment. The assessments are being done, but not documented in a timely manner. Going forward, at	02/02/2015	

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	<p>initiating a pharmacologic intervention..."</p> <p>2. Review of the facility policy "Adult/Geriatric Nursing Pain Protocol", last revised 12/03/2013, indicated, "IV. Procedure: Nursing Assessment: a. The nurse will assess the patient for presence or absence of pain as per the Nursing & Patient Care Services Policy, 'Assessment of Pain' for the adult patient. b. Treatment interventions will be initiated for scores of more than a 3 on patient population specific pain scales that are hospital approved. ...e. Patients will be reassessed after an intervention, and documented in the medical record within one (1) hour after the intervention."</p> <p>3. The medical record for patient #13, an 80 year old who had surgery at the facility on 10/08/14, indicated the following documentation: A. Medication given at 0728 hours on 10/09/14 for a pain score of 4 and no pain reassessment until 1013 hours. B. Medication given at 1754 hours on 10/09/14 for a pain score of 2 and no pain reassessment until 2304 hours. C. Medication given at 0659 hours on 10/10/14 for a pain score of 5 and no pain reassessment until 0915 hours.</p> <p>4. The medical record for patient #14, an 57 year old who had surgery at the</p>		<p>the change of shift, each patient's medical record will be reviewed by the outgoing nurse prior to the hand-over to the incoming nurse to verify that the documentation of pain assessment is complete. (See Attachment I - email sent to Inpatient Unit staff). 2. Increased monitoring and review of patient medical records should assure greater compliance with this requirement. For February, March, and April, 2015, 100% of patient records will be reviewed per month to assure compliance with pain documentation requirements.** Staff will be completing monthly monitoring activities using the Readiness Rounds tool to monitor for compliance. 3. Inpatient Unit Patient Care Coordinator will be responsible for ongoing surveillance for non-compliance. 4. New shift handover process to begin 2/2/15.**Note: Following the email sent to staff (attachment I), it was decided to change the frequency of patient medical record monitoring. Responsible Person: Inpatient Unit Patient Care Coordinator <u>S. 912, #4</u> 1. This deficiency is primarily one of failure to perform the appropriate documentation in the electronic medical record regarding the documentation of the required pain assessment and documenting in a timely manner that the pain assessment was done. Staff were informed of this documentation concern via</p>		

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	<p>facility on 10/20/14, indicated the following documentation:</p> <p>A. Medication given at 1110 hours on 10/20/14 for a pain score of 5 and no pain reassessment until 1347 hours.</p> <p>B. Medication given at 1803 hours on 10/20/14 for a pain score of 4 and no pain reassessment until 2033 hours.</p> <p>C. Pain medication given at 2220 hours on 10/20/14, but no pain score was documented.</p> <p>5. The medical record for patient #15, an 73 year old who had surgery at the facility on 09/15/14, indicated the following documentation:</p> <p>A. Medication given at 0823 hours on 09/16/14 for a pain score of 2 and no pain reassessment until 1031 hours.</p> <p>B. Medication given at 1238 hours on 09/16/14 for a pain score of 4, but no reassessment was documented.</p> <p>6. The medical record for patient #16, an 73 year old who had surgery at the facility on 10/06/14, indicated the following documentation:</p> <p>A. Medication given at 0347 hours on 10/07/14 for a pain score of 3 and no pain reassessment until 0632 hours.</p> <p>B. Medication given at 0728 hours on 10/07/14 for a pain score of 2 and no pain reassessment until 0955 hours.</p> <p>C. Medication given at 1059 hours on</p>		<p>e-mail reminding staff that any intervention for pain must be followed in an hour with a post-interventional assessment. The assessments are being done, but not documented in a timely manner. Going forward, at the change of shift, each patient's medical record will be reviewed by the outgoing nurse prior to the hand-over to the incoming nurse to verify that the documentation of pain assessment is complete. (See attachment I – an email sent to Inpatient Unit staff). 2. Increased monitoring and review of patient medical records should assure greater compliance with this requirement. For February, March, and April, 2015, 100% of patient records will be reviewed per month to assure compliance with pain documentation requirements.** Staff will be completing monthly monitoring activities using the Readiness Rounds tool to monitor for compliance. 3. Inpatient Unit Patient Care Coordinator will be responsible for ongoing surveillance for non-compliance. 4. New shift handover process to begin 2/2/15.**Note: Following the email sent to staff (attachment I), it was decided to change the frequency of patient medical record monitoring. Responsible Person: Inpatient Unit Patient Care Coordinator Completion Date: 2-2-15</p> <p><u>S 912, #5</u></p>				

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	<p>10/07/14 for a pain score of 3, but no reassessment was documented.</p> <p>7. The medical record for patient #18, an 71 year old who had surgery at the facility on 08/04/14, indicated the following documentation: A. Medication given at 0805 hours on 08/05/14, but no pain score was documented, with no pain reassessment until 1132 hours. B. Medication given at 1940 hours on 08/05/14 for a pain score of 4 and no pain reassessment until 2241 hours. C. Medication given at 2352 hours on 08/05/14 for a pain score of 8 and no pain reassessment until 0241 hours on 08/06/14.</p> <p>8. At 12:45 PM on 12/10/14, staff members #6, the Quality Manager, and #23, the Interim Director of HIM confirmed the medical record documentation was not according to facility policy and standards of practice.</p>		<p>1. This deficiency is primarily one of failure to perform the appropriate documentation in the electronic medical record regarding the documentation of the required pain assessment and documenting in a timely manner that the pain assessment was done. Staff were informed of this documentation concern via e-mail reminding staff that any intervention for pain must be followed in an hour with a post-interventional assessment. The assessments are being done, but not documented in a timely manner. Going forward, at the change of shift, each patient's medical record will be reviewed by the outgoing nurse prior to the hand-over to the incoming nurse to verify that the documentation of pain assessment is complete. (See attachment I – an email sent to Inpatient Unit staff).</p> <p>2. Increased monitoring and review of patient medical records should assure greater</p>		

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			<p>compliance with this requirement. For February, March, and April, 2015, 100% of patient records will be reviewed per month to assure compliance with pain documentation requirements.** Staff will be completing monthly monitoring activities using the Readiness Rounds tool to monitor for compliance.</p> <p>3. Inpatient Unit Patient Care Coordinator will be responsible for ongoing surveillance for non-compliance.</p> <p>4. New shift handover process to begin 2/2/15.</p> <p>**Note: Following the email sent to staff (attachment I), it was decided to change the frequency of patient medical record monitoring.</p> <p>Responsible Person: Inpatient Unit Patient Care Coordinator</p> <p><u>S 912, #6</u></p> <p>1. This deficiency is primarily one of failure to perform the appropriate documentation in the electronic medical record</p>	

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			<p>regarding the documentation of the required pain assessment and documenting in a timely manner that the pain assessment was done. Staff were informed of this documentation concern via e-mail reminding staff that any intervention for pain must be followed in an hour with a post-interventional assessment. The assessments are being done, but not documented in a timely manner. Going forward, at the change of shift, each patient's medical record will be reviewed by the outgoing nurse prior to the hand-over to the incoming nurse to verify that the documentation of pain assessment is complete. (See attachment 1 – an email sent to Inpatient Unit staff).</p> <p>2. Increased monitoring and review of patient medical records should assure greater compliance with this requirement. For February, March, and April, 2015, 100% of patient records will be reviewed per</p>		

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			<p>month to assure compliance with pain documentation requirements.** Staff will be completing monthly monitoring activities using the Readiness Rounds tool to monitor for compliance.</p> <p>3. Inpatient Unit Patient Care Coordinator will be responsible for ongoing surveillance for non-compliance.</p> <p>4. New shift handover process to begin 2/2/15.</p> <p>**Note: Following the email sent to staff (attachment I), it was decided to change the frequency of patient medical record monitoring. Responsible Person: Inpatient Unit Patient Care Coordinator <u>S 912, #7</u></p> <p>1. This deficiency is primarily one of failure to perform the appropriate documentation in the electronic medical record regarding the documentation of the required pain assessment and documenting in a timely manner that the pain assessment was done.</p>		

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			<p>Staff were informed of this documentation concern via e-mail reminding staff that any intervention for pain must be followed in an hour with a post-interventional assessment. The assessments are being done, but not documented in a timely manner. Going forward, at the change of shift, each patient's medical record will be reviewed by the outgoing nurse prior to the hand-over to the incoming nurse to verify that the documentation of pain assessment is complete. (See attachment 1 – an email sent to Inpatient Unit staff).</p> <p>2. Increased monitoring and review of patient medical records should assure greater compliance with this requirement. For February, March, and April, 2015, 100% of patient records will be reviewed per month to assure compliance with pain documentation requirements.** Staff will be completing monthly monitoring activities using</p>		

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			<p>the Readiness Rounds tool to monitor for compliance.</p> <p>3. Inpatient Unit Patient Care Coordinator will be responsible for ongoing surveillance for non-compliance.</p> <p>4. New shift handover process to begin 2/2/15.</p> <p>**Note: Following the email sent to staff (attachment I), it was decided to change the frequency of patient medical record monitoring. Responsible Person: Inpatient Unit Patient Care Coordinator <u>S 912, #8</u></p> <p>1. This deficiency is primarily one of failure to perform the appropriate documentation in the electronic medical record regarding the documentation of the required pain assessment and documenting in a timely manner that the pain assessment was done. Staff were informed of this documentation concern via e-mail reminding staff that any intervention for pain must be followed in an hour with a post-interventional</p>		

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			<p>assessment. The assessments are being done, but not documented in a timely manner. Going forward, at the change of shift, each patient's medical record will be reviewed by the outgoing nurse prior to the hand-over to the incoming nurse to verify that the documentation of pain assessment is complete. (See attachment 1 – an email sent to Inpatient Unit staff).</p> <p>2. Increased monitoring and review of patient medical records should assure greater compliance with this requirement. For February, March, and April, 2015, 100% of patient records will be reviewed per month to assure compliance with pain documentation requirements.** Staff will be completing monthly monitoring activities using the Readiness Rounds tool to monitor for compliance.</p> <p>3. Inpatient Unit Patient Care Coordinator will be responsible for ongoing surveillance for</p>		

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on document review and interview, the facility failed to follow their policy for 2 of 3 patients (#5 and #6) who received blood transfusions as outpatients at the facility.</p> <p>Findings included:</p> <p>1. The facility policy "Administration of Blood and Blood Components", last revised 12/12/13, indicated, "VI.</p>	S000952	<p>non-compliance. 4. New shift handover process to begin 2/2/15. **Note: Following the email sent to staff (attachment I), it was decided to change the frequency of patient medical record monitoring. Responsible Person: Inpatient Unit Patient Care Coordinator</p> <p>Deficiency S 952 2</p> <p>It was identified by the Practice Manager of the Outpatient Infusion Center that the Infusion Center was referencing an expired policy regarding the need to obtain consents more often for outpatient transfusions. Nursing staff for the Outpatient Infusion Center were sent the following documents: Email with read receipt (attachment J) sent on 2-2-15, Administration of</p>	02/02/2015	

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	<p>Procedure: A. Obtaining Consent: 1. Check the patient hard chart for a signed 'Consent for Blood/Blood Component Transfusion' form. If not completed, obtain consent following Administrative Policy, Informed Consent for Blood Transfusion, #950.46. ...2. For Outpatients requiring T&S [type and screen], or Blood Components order, the orders may be put into the system and the specimen may be drawn without obtaining blood consent. It is then the responsibility of the nursing personnel at the transfusion location to get the 'Consent for Blood Transfusion' form signed."</p> <p>2. The medical record for patient #5, who received a blood transfusion as an outpatient at the facility on 01/15/14, lacked documentation of a properly executed consent form.</p> <p>3. The medical record for patient #6, who received a blood transfusion as an outpatient at the facility on 09/02/14, lacked documentation of a properly executed consent form.</p> <p>4. At 11:45 AM on 12/10/14, staff member #23, the Interim Director of HIM confirmed the consents needed to be obtained prior to blood transfusions. He/she indicated patients who came as</p>		<p>Blood and Blood Components policy (attachment K), and Administrative Policy and Procedure regarding Informed Consent for Blood Transfusions. (See attachment L.) Staff were informed that blood consents are to obtained with each current outpatient infusion center admission. Nursing staff will obtain with each blood transfusion a new informed blood consent. This information was sent to the Outpatient Infusion Center staff via e-mail in a manner such that a read receipt will be sent back to the Practice Manager for documentation that the staff members have received the blood consent and blood administration policies and have an understanding of the email. The Practice Manager is also going to see that a box is added to their electronic medical documentation system (ARIA) and staff will check that box indicating they have obtained the blood consent. To prevent this document deficiency in the future, documentation of blood consents will be monitored for 3 months by completing documentation audits.</p> <p>Responsible Parties: Practice Manager Outpatient Infusion Center Manager</p> <p>Deficiency S 952 3</p> <p>It was identified by the Practice</p>				

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	outpatients for a series of transfusions could use one signed consent, but confirmed no consents could be found for patients #5 and #6.		Manager of the Outpatient Infusion Center that the Infusion Center was referencing an expired policy regarding the need to obtain consents more often for outpatient transfusions. Nursing staff for the Outpatient Infusion Center were sent the following documents: Email (attachment J) with read receipt sent on 2-2-15, Administration of Blood and Blood Components policy (attachment K), and Administrative Policy and Procedure regarding Informed Consent for Blood Transfusions. (See attachment L.) Staff were informed that blood consents are to obtained with each current outpatient infusion center admission. Nursing staff will obtain with each blood transfusion a new informed blood consent. This information was sent to the Outpatient Infusion Center staff via e-mail in a manner such that a read receipt will be sent back to the Practice Manager for documentation that the staff members have received the blood consent and blood administration policies and have an understanding of the email. The Practice Manager is also going to see that a box is added to their electronic medical documentation system (ARIA) and staff will check that box indicating they have obtained the blood consent. To prevent this document deficiency in the future, documentation of blood consents will be monitored for 3 months by completing		

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			<p>documentation audits.</p> <p>Responsible Parties: Practice Manager Outpatient Infusion Center Manager</p> <p>Deficiency S 952 4</p> <p>It was identified by the Practice Manager of the Outpatient Infusion Center that the Infusion Center was referencing an expired policy regarding the need to obtain consents more often for outpatient transfusions. Nursing staff for the Outpatient Infusion Center were sent the following documents: Email (attachment J) with read receipt sent on 2-2-15, Administration of Blood and Blood Components policy (attachment K), and Administrative Policy and Procedure regarding Informed Consent for Blood Transfusions. (See attachment L.) Staff were informed that blood consents are to obtained with each current outpatient infusion center admission. Nursing staff will obtain with each blood transfusion a new informed blood consent. This information was sent to the Outpatient Infusion Center staff via e-mail in a manner such that a read receipt will be sent back to the Practice Manager for documentation that the staff members have received the blood consent and blood administration policies and have an understanding of the email. The Practice Manager is also going</p>	

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation and staff interview, the hospital failed to comply with manufacturer recommended operating temperature for the Hydrocollator in the Rehabilitation Department and failed to ensure</p>	S001118	<p>to see that a box is added to their electronic medical documentation system (ARIA) and staff will check that box indicating they have obtained the blood consent. To prevent this document deficiency in the future, documentation of blood consents will be monitored for 3 months by completing documentation audits.</p> <p>Responsible Parties: Practice Manager Outpatient Infusion Center Manager</p> <p>S1118 – 1 The rehabilitation department recognizes that the recommended operating temperature is 160-165 degree Fahrenheit. The water temperature is logged daily by the Rehabilitation Tech as well as checked before using the Steam Packs on each patient. If the temperature is outside of the</p>	12/15/2014	

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	<p>the only hand washing sink in the kitchen was in working condition.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Operation Manual instructions for the use and operation for Rehabilitation Department's Hydrocollator M-2 Master Heating Units notes the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 165 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs. 2. The Rehabilitation Department Hydrocollator M-2 Master Heating Unit 2014 temperature logs were reviewed from September 8 to December 10. The department recorded the temperature of the water once a week, Monday through Friday. The temperature logs revealed the water exceeded 		<p>operating temperature, Biomed will be notified and the Steam Packs will not be used until the temperature returns to the operating range. (See attached water logs – attachment M.) Responsible Person: Rehab Tech S1118 – 2 The water logs revealed the water exceeded 166 degrees Fahrenheit for 61 of 68 reviewed days. The water temperature is logged daily by the Rehabilitation Tech as well as checked before using the Steam Packs on each patient. If the temperature is outside of the operating temperature, Biomed will be notified and the Steam Packs will not be used until the temperature returns to the operating range. (See attached water logs – item M.) Responsible Person: Rehab Tech Biomed Engineer S1118 – 3 The department was using a stem thermometer that allows for error, preventing an accurate reading. Biomed purchased a digital Medics thermometer that reports to one decimal point. (See attached order 254413 – attachment N.) The Rehabilitation Department implemented use of the more specific thermometer on December 15, 2014. The accuracy of the thermometer will be checked yearly by Biomed. The water temperature is logged daily as well as checked before using the Steam Packs on each patient. (See attached water log – attachment M.) If the</p>		

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	<p>166 degrees Fahrenheit for 61 weeks. The temperature of the water exceeded 170 degrees F at least 50 weeks of those 61 weeks.</p> <p>3. At 9:30 AM on 12/10/2014, staff member #28 (Biomedical Engineer) confirmed the weekly Hydrocollator temperature logs evidenced the water temperature exceeded 165 F most of the time. The staff member indicated the Rehabilitation Department staff members were using a stem thermometer that does not record an accurate water temperature.</p> <p>4. At 10:30 AM on 12/9/2014, the hand washing sink in the kitchen was observed without faucet handles.</p> <p>5. At 11:10 AM on 12/9/2014, staff member #27 (Engineer Manager) confirmed the hand washing sink has not been in working condition for a couple of days because he/she was waiting on parts to repair the only hand</p>		<p>temperature is outside of the operating temperature, Biomed will be notified and the Steam Packs will not be used until the temperature returns to the operating range. Responsible Person: Rehab Tech Biomed Engineer ID Prefix Tag S 1118 - 4 Staff will be trained to use the sink outside of the kitchen for handwashing should there be a problem with the kitchen sink. Staff will be informed to leave the door open if the handwashing sink is not operational. This information was provided to staff in a powerpoint presentation distributed to all staff preparing food for patients. This was specifically addressed on page 5 of the powerpoint presentation noting what to do if hand washing sink is not operational. (see page 5 of the attachment B.) The faulty faucet for the sink located in the kitchen was replaced with a new faucet and the sink returned to service on December 9, 2014. (See attachment C - Engineering Work Order #483325 documenting the repair.) The sink should not have been taken out of service until the parts were available to make repairs or temporary arrangements made to provide alternate means for employees to wash their hands. The Director of Engineering will be responsible for reviewing with Engineering staff the Infection Prevention Policy for Engineering at the next department meeting</p>	

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	sink in the kitchen.		scheduled for February 19, 2015. Responsible Persons: Director of Food and Nutrition Services - CIR Director of Engineering ID Prefix Tag S 1118 - 5 Staff will be trained to use the sink outside of the kitchen for handwashing should there be a problem with the kitchen sink. Staff will be informed to leave the door open if the handwashing sink is not operational. This information was provided to staff in a powerpoint presentation distributed to all staff preparing food for patients. This was specifically addressed on page 5 of the powerpoint presentation noting what to do if hand washing sink is not operational. (see page 5 of Attachment B - the attached powerpoint presentation.) The faulty faucet for the sink located in the kitchen was replaced with a new faucet and the sink returned to service on December 9, 2014. (See attachment C - Engineering Work Order #483325 documenting the repair.) The sink should not have been taken out of service until the parts were available to make repairs or temporary arrangements made to provide alternate means for employees to wash their hands. The Director of Engineering will be responsible for reviewing with Engineering staff the Infection Prevention Policy for Engineering at the next department meeting scheduled for February 19, 2015. Responsible Persons: Director of		

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

PRINTED: 02/11/2015

FORM APPROVED

OMB NO. 0938-0391

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