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	151325	A. BUILDING 00 B. WING	11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S WARRICK HOSPITAL, INC	1116 MILLIS AVE BOONVILLE, IN 47601

(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 State licensure survey. Facility number: 005111 Dates: 11/9/15 to 11/10/15 QA: cjl 12/11/15	S 0000		
S 0256 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(2)(A)(B) (a) The Governing Board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (2) Ensure that the hospital: (A) meets all rules and regulations for licensure and certification, if applicable; and (B) makes available to the commissioner upon request all reports, records, minutes, documentation, information, and files required for licensure. Based on interview, the governing board failed to ensure the hospital made	S 0256	A plan for all future surveys was written up by the Accreditation	11/17/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	personnel files available upon request for 10 personnel requested (housekeeping director, a housekeeping personnel, a maintenance personnel, medical records director, occupational therapist, pharmacy director, pharmacy technician, physical therapy director, radiology technician and speech therapist). Findings: 1. On 11/9/15 at 10:30am, during opening conference, personnel records were requested for individuals holding the following positions: housekeeping director, a housekeeping personnel, a maintenance personnel, medical records director, occupational therapist, pharmacy director, pharmacy technician, physical therapy director, radiology technician and speech therapist. A written request list was provided to A4, Executive Director and A1, Director of Inpatient Nursing. 2. On 11/10/15 at 2:00pm, A16, Human Resources Manager, indicated he/she was unaware of personnel files needed for housekeeping director, a housekeeping personnel, a maintenance personnel, medical records director, occupational therapist, pharmacy director, pharmacy technician, physical therapy director, radiology technician and speech therapist		Manager and the Hu7man Resources Manager. It is as follows:All vital point persons (Directors and Managers of EVS, Food Services, Laboratory, Radiology, Facilities, Pharmacy, Infection Control, Quality, Safety/Security, Human Resources, Risk Management, etc.) will be expected to gather in the Administration after opening. A sign-in sheet will be passed out, including contact numbers where they may be reached during the survey process. Assignments will be given to begin organizing the document collection requirements. A room will be set up for the accreditation staff. Everything collected (all documents, files) must go through the Accreditation Manager and Senior Analyst prior to handing it over to the surveyors. All staff must check in with Accreditation so they are aware of who is speaking with the surveyors (e.g. text messages, phone call). Accreditation will be responsible for maintaining the Master List (assignments will be on it). Items will be checked off of the list as they are given to surveyors. Each AM during the week of the survey, requested daily documents must be in the Accreditation staff's work room by 8:00 AM. When a person outside of HR receives a name or list of names, the surveyor wishes to have human resources/associate health documents to review,	

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	and indicated the list may not have gotten to employee health as well. 3. On 11/10/15 at 2:10pm, A15, Associate Health Coordinator, indicated the employee health files for the housekeeping director, a housekeeping personnel, a maintenance personnel, medical records director, occupational therapist, pharmacy director, pharmacy technician, physical therapy director, radiology technician, and speech therapist had not been pulled. 4. On 11/10/15 at 5:30pm, A12, Accreditation Manager, indicated some, but not all of the personnel files requested were available. A12 indicated files were not available on site and had to be sent in from Indianapolis and/or the primary Evansville hospital. A12 indicated the files would not be available by time of exit at 5:45pm, 11/10/15.		he/she must contact the HR point person and provide the names/list directly to the point person. The HR point person will contact the department to obtain the department file and associate health to coordinate with them. We will work with all contracted personnel agencies to ensure copies of requested personnel records of contracted can be obtained in a prompt and timely manner. Copy list and give to Human Resources point person and Accreditation staff. We need to ensure promptness of delivery for the surveyors to review and that no files are omitted. All associate/contingent workers (including department) files must go through the Human Resources point person prior to handing them to the surveyor. The Human Resources point person will be present with the surveyor during file review. The Accreditation Manager and the HR Manager will be responsible to ensure this practice so the surveyors receive their files in a timely manner. It has been communicated out to St. Mary's Warrick leadership by the Accreditation Manager. It went into effect immediately after approval for the next survey.	
S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT			

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	410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the quality assessment and performance improvment (QAPI) failed to include 7 directly provided services (central sterile, computed tomography scans, infusion therapy, Magnetic Resonance Imaging, post-operative recovery, outpatient surgical services and ultrasound) and 2 contracted services (anesthesia and laundry) in its evaluations for 2015. Findings: 1. Review of QAPI meeting minutes and reports for 2015 lacked documentation of quality evaluations for the following directly provided services: central sterile, computed tomography scans, infusion therapy, Magnetic Resonance Imaging, post-operative recovery, outpatient surgical services and ultrasound and the contracted services of anesthesia and	S 0406	The Executive Director of Quality for St. Mary's Health, the St. Mary's Warrick Quality Data Analyst, St. Mary's Warrick Director of Outpatient Services met on December 17, 2015 to discuss capturing each of these seven areas. It was determined that to be reported to Quality Committee on a rotating basis in the monthly quality meetings and then up to the Board. There will be ongoing auditing of all modalities. An excel spreadsheet has been developed with the quality indicator and their benchmarks that will be monitored for: central sterile, computed tomography scans, infusion therapy, Magnetic Resonance Imaging, post-operative recovery, outpatient surgical services and ultrasound, and the contracted services, anesthesia and laundry. The Director of Outpatient Services will be held accountable for ensuring these areas are	01/01/2016

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	laundry. 2. On 11/10/15 at 4:45pm, A2, Director of Outpatient Nursing, indicated central sterile, computed tomography scans, infusion therapy, Magnetic Resonance Imaging, post-operative recovery, outpatient surgical services, ultrasound and the contracted services of anesthesia and laundry were not included in QAPI evaluations for 2015.		captured on the QAPI evaluations.	
S 0408 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (2) All functions, including but not limited to the following: (A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).			

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	Based on document review and interview, the quality assessment and performance improvment (QAPI) failed to include 3 functions in its evaluations for 2015. Findings: 1. Review of QAPI meeting minutes and reports for 2015 lacked documentation of quality evaluations for the following functions: response to patient emergency, transcription and utilization review. 2. On 11/10/15 at 4:45pm, A2, Director of Outpatient Nursing, indicated the functions of Response to patient emergency, transcription and utilization review were not included in QAPI evaluations for 2015.	S 0408	The Executive Director of Quality for St. Mary's Health, the St. Mary's Warrick Quality Data Analyst, the St. Mary's Warrick Director of Outpatient Services (responsible for quality at St. Mary's Warrick), and the St. Mary's Warrick Administrator met on December 17, 2015 to discuss capturing each of these areas to be reported out quarterly on a rotating basis in the monthly quality meetings and then up to the Board. An excel spreadsheet has been developed with the quality indicator and their benchmarks that will be monitored for the functions: response to patient emergency, transcription and utilization review. Regarding Response to Patient Emergencies: Audits of Patient emergencies to include all Rapid Response and Codes will be audited both in a post emergent Huddle and via documentation. A Code/Emergency Team has been assembled to provide oversight and monitoring of all codes/Rapid Response events. Findings will be reported to Medical Staff and the Board on a quarterly basis. This process was planned on 12/17/2015. The process of including each modality and area in reports to the Quality Committee begins In the January, 2016 meeting.	01/01/2016

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			The Director of Inpatient Services will be responsible for monitoring and ensuring completion of these activities.	
S 0508 Bldg. 00	410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1(b)(1)(A)(B) (b) The food and dietetic service shall have the following: (1) A full-time employee who: (A) serves as director of the food and dietetic services; and (B) is responsible for the daily management of the dietary services. Based on document review and observation, the hospital failed to ensure foods in one area (XRay room 2) were kept according to policy. Findings: 1. Review of the policy titled Patient Food Services/Nursing Unit Stock, indicated items without individual dates (i.e. crakers) are sent in ziplock bag and dated appropriately per dating policy. The policy was revised 3/14. 2. On 11/10/15 at 10:30am, in the presence of S2, Radiology Technician, and A11, Director of Facilities, the following was observed in a cabinet in XRay room 2: 1 plastic cup of apple juice, 2 packages of crackers, 3 packages	S 0508	All food items will be retrieved from the dietary department per each use. No food or drink will be maintained in the Radiology Department. Education of employees to refrain from leaving any food or drink in the Radiology department was presented and posted on 11/10/2015. The Director of Outpatient Services will monitor the department with a weekly walkthrough. The Director of Outpatient Services will be responsible to ensure staff is following the requirement.	11/10/2015

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	Thick n Ready mix (one with a brownish sticky appearing substance on the outside of the package). The items lacked indication of individual expiration dates and were not in dated bags.			
S 0554 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, the facility failed to provide an environment that minimized risk to patients on 1 of 4 units/departments toured (emergency department [ED]). Findings include: 1. During tour of the ED beginning at 12:25 p.m. on 11/10/15, numerous expired items were observed in the trauma room including, but not limited to, the following: (A) A Laryngeal Mask with an expiration date of 2/15. (B) Two (2) 16 gauge Angiocaths with an expiration date of 1/15. (C) 2 expired 18 gauge Angiocaths. One	S 0554	All expired supplies (laryngeal mask, 16 gauge angiocaths, 18 gauge angiocaths, glidescope, arterial blood sampling kit, and 2 pediatric lumbar puncture trays) were replaced as soon as they could be obtained (within 48 hours). The supplies had been replaced by 11/12/2015. The daily checklist has been revised to provide for more accurate accountability and tracking of expiration of supplies. All emergency carts were reviewed for expired supplies, equipment, and medications, bringing all carts into compliance. This project was completed on November 17, 2015. A crash cart team will be assembled to provide oversight for the process for all emergency carts within the facility. The Director of Outpatient	11/17/2015

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	1 with an expiration date of 2/15 and 1 with an expiration date of 6/15. (D) A glidescope with an expiration date of 1/15. (E) An arterial blood sampling kit within the pediatric crash cart with an expiration date of 2/15. (F) 2 pediatric lumbar puncture trays with expiration dates of 4/14 and 6/14.		Services will be accountable for oversight. The department charge nurses will spot check the carts monthly for compliance.	
S 0570 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed. Based on interview and document	S 0570	The physician member of the Infection Control Committee was	12/17/2015

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	review, the facility failed to ensure a representative from the medical staff attended infection control meetings for 11 of 12 meetings held. Findings include: 1. Staff member #N1 indicated in interview beginning at 9:30 a.m. on 11/10/15 that M.D. #1 was the medical representative on the infection control committee. 2. Review of infection control meeting minutes for previous twelve (12) months indicated meetings are held on a monthly basis and M.D. #1 was present at only one (1) meeting held on 5/21/15 during the 12 month period.		contacted and had it added to his calendar to provide for at the minimum, quarterly attendance. The Chair of the Medical Staff will also attend when available. A conference call option has been provided for dates that the physicians are unable to attend on the St. Mary's Warrick Hospital campus. Physician attendance to the meetings will be monitored to ensure attendance, at a minimum, quarterly. This began December 17, 2015 at the monthly meeting. The Chair of the Medical Staff will be accountable to ensure physician representation.	
S 0592 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i) (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			

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	limited to, the following: (i) Sanitation. Based on document review and interview, the facility failed to ensure patient care areas were cleaned per policy for 1 of 4 units/departments toured (surgery). Findings include: 1. Facility policy titled "Restroom Cleaning" last reviewed/revised 6/27/14 states on page 3: "J. Sink: 1. Wipe with a clean cloth using a facility approved germicidal solution. Be sure to clean the faucets, surface surrounding the sink, and all metal handles.....K. Commodes and Urinals:.....2. Spray germicidal cleaning solution on the interior of the fixture. Clean the inside of the commode or urinal with the bowl mop.....3. Dampen a clean cloth with germicidal solution and wipe the outside surface of the commode or urinal....." 2. During tour of the surgery department beginning at 12:50 p.m. on 11/10/15, staff member #N2 (RN) indicated that cleaning restrooms between patients in the surgery/recovery area is conducted by staff in the department and the commodes are cleaned with Porcelain and shower cleaner and the sinks are cleaned with	S 0592	Environmental services worked with the surgery staff on the proper use of on the proper use of the correct products with germicidal properties. All Surgery Associates have been in-serviced per policy and have signed off on the policy. When a new product is introduced by environmental services, the staff will be educated on its usage. All in-servicing of staff was completed by 11/16/2015. Responsibility to ensure monitoring of proper cleaning with the correct supplies will occur by Director of Outpatient Services.	11/16/2015

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	Comet Creme Deodorizing Cleanser. 3. Review of labels for the Porcelain and shower cleaner and the Comet clean indicated they had no germicidal properties.			
S 0596 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (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: (iii) Cleaning, disinfection, and sterilization. Based on observation and document review, the infection control committee failed to ensure the ceilings within the sterile processing area and instrument storage area were constructed according to acceptable standards of practice for one (1) sterile processing area toured.	S 0596	The fiberboard porous ceiling tiles in the sterile processing area will be replaced with appropriate nonporous tiles which can be cleaned. This project will be completed by 1/20/2016 The Director of Facilities is responsible for ensuring timely replacement of these tiles.	01/20/2016

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	Findings include: 1. During tour of the sterile processing area beginning at 12:50 p.m. on 11/10/15, it was observed that the ceilings within the wrapping/sterile processing area and the instrument storage area were constructed of porous fiberboard type ceiling tiles that would not withstand cleaning agents. 2. CDC document titled "Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008" states under physical facilities: "The floors and walls should be constructed of materials capable of withstanding chemical agents used for cleaning or disinfecting. Ceilings and wall surfaces should be constructed of non-shedding materials."			
S 0610 Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (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			

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	which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based upon document review, observation and staff interview, the facility failed to assure that the infection control committee ensured the cafeteria's food storage program met applicable temperature storage requirements as required by the hospital's policy for one (physician lounge) of six temperature storage spaces serviced by the kitchen. Findings include: 1. Review of the policy Temperature Monitoring, Cleaning of Refrigerators, and Food	S 0610	A temperature log has been placed on this refrigerator and is being monitored and logged daily by the Food Services department. The Food Services staff has been in-serviced on the log and daily requirements of monitoring. This was completed by 11/9/2015. All temperature logs will be checked monthly for completion during the monthly infection control surveillance walk through. The Manager of Food Services is responsible to ensure that the Supervisor of Food Services is ensuring per policy.	11/16/2015

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	Labeling (infectious Disease), Policy Stat ID: 1189374, reviewed on 11/09/15, indicated: Unit/department designee will obtain temperature log, record temperature, take action and date the employee food temperature log. Temperature ranges: For patient or associate food storage maintain refrigerator between 32 degrees to 41 degrees Fahrenheit (F). 2. On 11/09/15 at 12:40 p.m., it was noted that the physician lounge refrigerator had no ongoing cold food storage temperature log available for review. 3. On 11/09/15 at 12:45 p.m., staff member #A5 confirmed the kitchen had not followed the above-listed policy to assure maintenance of a cold food storage temperature log for the physician lounge refrigerator.			
S 0754 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)			

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	(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. **Based on document review and staff interview, the hospital failed to follow hospital policy of informed consent for one patient (Patient #7) of eight patients receiving blood.** **Findings included:** **1. Review of the policy Blood and Blood Components Administrations, Guidelines and Table, Policy Stat ID: 1781857, reviewed 10/5/15, indicated: Only one consent is needed per hospital stay or series of outpatient treatments.** **2. Review of medical records of eight patients receiving blood**	S 0754	On 12/18/2015, education was completed to all staff who administer blood and obtain consents. . The information presented in the education included the requirement that a blood consent must be signed per hospital stay or if an order is a series order (i.e. Administer 1 unit of blood once a month for 3 months.) A copy of the series order consent must be placed on the chart each outpatient visit. 50% of Blood transfusion charts, not to exceed 10 charts, will be audited monthly for completion and appropriateness of consent. Monthly monitoring and reporting of results will be presented quarterly to the quality committee. The first CORE meeting for reporting will occur on 1/20/2016. The Director of Outpatient Services will be accountable to ensure this is completed and follow-up with concerns is performed.	12/18/2015

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	indicated lack of a consent form for Patient #7. **3. In interview on 11/09/15 at 12:55 p.m., staff member #A14 confirmed all the above and no other documentation was provided by exit.**			
S 1014 Bldg. 00	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c) (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals. Based on document review and observation, the pharmacy failed to ensure policies for medication storage and medication security were followed on the Behavioral Health Unit (BHU). Findings include: 1. Facility policy titled "Medication: Controlled Substances-Storage, Ordering,	S 1014	The licensed staff member who left the medications unsecure was counseled by the Nurse Manager on November 11, 2015. All licensed staff was educated regarding policy for securing, storage and handling of home medications. This was completed on November 24, 2015. Pharmacy will conduct weekly inspection of nursing unit for 3 months to ensure proper storage of all medications. If medications	11/24/2015

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	Dispensing, Discrepancies, Waste-Outside of the Pharmacy Department" last reviewed/revised 8/1/14 states under policy statement: "Pyxis Medstations serve as the primary method for the storage, distribution, tracking, and security of controlled substances in drug storage areas outside of the pharmacy." Page 2 states: "5. All controlled substance floorstock not stored in Pyxis must be stored securely in double locked cabinets and/or drawers." 2. Facility policy titled "Medication Security" last reviewed/revised 8/20/14 states under policy statement: "All medications, prescription and non-prescription, stored in the pharmacy and throughout the hospital and off-campus locations will be stored in a secure manner." The policy states under procedure: "B. Locked storage is the preferred form of providing security." 3. Facility policy titled "Medication Storage" last reviewed/revised 9/29/14 states on page 2 under storage locations: "4. Nursing Units a. All patient specific medications kept on the nursing units are stored in locking medication carts or cabinets." 4. During tour of the BHU beginning at 10:40 a.m. on 11/10/15 and accompanied		are found to be unsecured, a pharmacist will stay with meds until an RN secures them. A report will be written and provided to the Nurse Manager and the Director of Inpatient Services. This will begin the week of November 23, 2015. The Director of Inpatient Services will be responsible to ensure medications are secured per policy by staff.	

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	by staff members #AA2 and AA3, the following observations were made: (A) The medication cart at the nurse station was unlocked and contained medications including, but not limited to, one (1) bottle of Trazodone, an Advair inhaler system, a vial of Humalog Insulin, and 1 bottle of Lorazepam (a controlled substance). (B) There were no staff members at the nurse station upon arrival to the nurse station. (C) There was a Pyxis Medstation next to the medication cart.			
S 1024 Bldg. 00	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction. Based on observation, the pharmacy failed to remove outdated intravenous	S 1024	All expired pharmaceutical supplies (IV solutions of Lactated	11/17/2015

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	(IV) solutions from general stock for 1 of 4 units/departments toured. Findings include: 1. During tour of the Emergency Department beginning at 12:25 p.m. on 11/10/15, the following expired IV solutions were observed in the trauma room: (A) Four (4) bags of Lactated Ringers with expiration dates of 5/14, 3/15 two (2) bags, and 5/15. (B) Three (3) bags of Sodium Chloride with expiration dates of 4/14 (2 bags) and 10/14.		Ringers and Sodium Chloride) were replaced immediately on 11/10/2015. The daily checklist has been revised to provide for more accurate accountability and tracking of expiration of supplies. All emergency carts were reviewed for expired supplies, equipment, and medications, bringing all carts into compliance. A crash cart team will be assembled to provide oversight for the process for all emergency carts within the facility. This project was completed on November 17, 2015. The department charge nurses will spot check the carts monthly for compliance. The Director of Outpatient Services will be accountable for oversight	
S 1118 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation and interview, the facility failed to provide a safe environment for patients on the	S 1118	Shower rods which are not break away are to be removed and replaced with anti-ligature shower rods in all patient bathrooms.	12/16/2015

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	Behavioral Health Unit (BHU) for all patients on the unit. Findings include: 1. During tour of the unit beginning at 10:40 a.m. on 11/10/15, it was observed that the shower curtain rods within the patient rooms were pieces of heavy PVC (polyvinyl chloride)pipe. 2. Staff member #AA2 (Program Director) indicated at time of observation that the pipes were in each room and installed by the facility after he/she started working on the unit. 3. Staff member #AA5 (Director of Facilities) indicated in interview at 2:05 p.m. on 11/10/15 that he/she has no record of testing on the PVC pipes and no proof that they were indeed break away devices.		Anti-ligature shower rods were ordered December 1, 2015. The anti-ligature shower rods were installed on December 16, 2015. All future shower rods ordered are required to be anti-ligature/ break away shower rods. The responsible party is the Director of Inpatient Services.	
S 1166 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C) (d) The equipment requirements are as follows: (2) There shall be sufficient			

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	equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks. **Based on document review and staff interview, the laboratory failed to assure that appropriate temperature records for the auxillary blood bank alarm had been documented and in working order for two of two months during 2015.** **Findings included:** **1. Review of the policy, Blood Storage, revised 2/15, indicated: Alarm Testing: The recording thermometer and alarms should be checked twice a month.** **2. Review of the Blood Bank Alarm check log for September and October 2015 indicated the blood bank alarm was checked twice per month for individual warm or cold temperatures in**	S 1166	The Manager of Laboratory Support Services instructed the blood bank staff on the appropriate testing of placing the probe in the chilled water and then into the warm water. The education occurred the week of the survey November 10 and 11, 2015. The requirement is to perform test quarterly of Laboratory Support Services for St. Mary's Health revised the policy, "St. Mary's Warrick Blood Bank Alarm Test" policy. It was posted on December 10, 2015. The blood bank staff was required to review the policy. The review by staff was completed by 12/19.2015. The Manager of Laboratory Support Services for St. Mary's Health is responsible for oversight of the correct process for testing the blood bank alarm.	12/19/2015

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	lieu of both warm/cold temperatures checked together twice per month: **Date Warm/Cold (2015)** **9/04 warm/missing** **9/24 massing/cold** **10/07 warm/missing** **10/23 missing/cold** **3. On 11/10/15 at 11:10 a.m., staff member #A7 confirmed the laboratory had not documented both warm/cold alarm checks together twice per month in blood bank.**			
S 1172 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the			

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	current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on document review, observation and interview, the hospital failed to ensure the building, fixtures, walls, floors and furnishings were kept clean in 5 areas (cardiac rehabilitation, generator room, computed tomography (CT) room, dumpster grounds and the loading dock area). Findings: 1. Review of the policy titled Cleaning of Non-Critical, Reusable Patient Care Equipment Using Hospital Approved Product, indicated the following: All equipment must be cleaned immediately if visibly soiled...regardless of cleaning schedule. The policy was last revised 9/13/14. 2. Review of the policy titled Infection Control Physical Medicine, indicated the following: Gym equipment is wiped after every used with hospital-approved disinfectant. The policy was revised 10/23/15. 3. On 11/10/15 at 10:15am during facility tour, the following was observed: In the cardiac rehabilitation gym, in the	S 1172	1. The gym equipment was thoroughly cleaned on 11/23/2015 the gym equipment will be monitored weekly to ensure it is wiped after every use with hospital-approved disinfectant. In addition, the Coordinator of Physical Medicine has initiated a weekly cleaning schedule beginning 11/23/2015 for gym equipment using hospital-approved disinfectant. The Coordinator of Physical Medicine will monitor and observe the process. The Manager of Physical Medicine will be responsible to ensure the cleaning occurs per policy.2. These tiles were replaced in the CT room closet on December 18, 2015. This area has been added to the environmental inspection that is performed monthly by the Coordinator of Engineering Services. St. Mary's Facilities Director is responsible to ensure the Engineering Coordinator completes the monthly inspections.3. The generator room was thoroughly cleaned after the removal of clutter, debris, rubbish, and a washing machine. Boxes are no longer on the floor. The Engineering Coordinator has initiated a plan for quarterly cleaning in addition to as needed cleaning of this	12/18/2015

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	presence of S1, Rehabilitation Coordinator, and A11, Director of Facilities, were 2 elliptical machines, both with heavy dust and black debris along the bottom side rails/tracks and one with dried liquid appearing droplet stains. At 11:10am, in the CT room closet, in the presence of A11, Director of Facilities, and A13, Facilities Coordinator, were two ceiling tiles with brownish moisture stains. At 11:40am, in the generator room, in the presence of A11, Director of Facilities, and A13, Facilities Coordinator, the floors were observed to be dirty with areas of debris, cluttered with rubbish, including a rusted washing machine, and 6 large boxes sitting on the floor. At 12:00pm, in the presence of A11, Director of Facilities, and A13, Facilities Coordinator, two dumpsters below the loading dock area were observed with trash and rubbish on the ground around the dumpsters, including, but not limited to, a black plastic bag partially full, gloves, and a broken light bulb. In that same area on the concrete dock above the dumpsters, 3 walls were observed to be heavily covered with insect nest/web like structures with black specks inside and the corners of the walls were caked with blackish debris. 4. On 11/10/15 at 4:30pm, A11 indicated the hospital did not have a policy for		room. This area was added to the monthly environmental inspections to be inspected for cleanliness by the Engineering Coordinator. The cleaning and removal of rubbish was completed by 12/7/2015. The Director of Facilities is responsible for ensuring the area is kept clean by the Engineering Coordinator.4. The Engineering Coordinator initiated a thorough cleaning of the area around the dumpsters on 11/19/2015, and a developed a plan for quarterly cleaning, and as needed, of this area. The 3 walls with debris were pressure-washed on 11/19/2015. These areas will be inspected for cleanliness during the monthly environmental inspection by the Engineering Coordinator. The Director of Facilities is responsible for ensuring the area is kept clean by the Engineering Coordinator. 5. Medxcel (the contracted facilities company) has provided a policy called “Routine Rounds” that addresses cleanliness and regular inspections. It has been reviewed by the Director of Facilities and the Engineering Coordinator at Warrick Hospital. It will be placed into our Policy Stat system. The Director of Facilities is responsible for ensuring the policy is implemented. He or his designee will perform monthly checks of the environment.	

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	keeping the facility/environment clean.			
S 1197 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the hospital failed to provide evidence of regular inspection by a State or local fire control agency within the past 22 months. Findings: 1. Review of fire inspection documentation indicated the most recent State or local fire inspection was dated 12/30/13. 2. On 11/10/15 at 3:30pm, A13, Facilities Coordinator, indicated the hospital had not had a fire inspection since 12/30/13. A13 indicated correspondance evidence requesting an inspection could not be provided.	S 1197	This inspection occurred on 11/23/2015 by the State Fire Marshall. The Engineering Coordinator is responsible for keeping a hard copy of evidence of all correspondence with the local and state fire agency. The Facilities Department has added this as a line item during their annual documentation review. Fire inspection completed 11/23/2015. – No findings noted. The Director of Facilities is responsible for ensuring the fire inspections occur per requirements.	11/23/2015

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S 1804 Bldg. 00	410 IAC 15-1.6-5 PSYCHIATRIC SERVICES 410 IAC 15-1.6-5(a) (a) If the hospital provides psychiatric services, the service shall meet the needs of the patients served, within the scope of the service offered, in accordance with acceptable standards of practice. Based on document review and interview, the facility failed to ensure Psychosocial Assessments were completed per policy for 2 (patients #8 and 11) of 3 patients on the Behavioral Health Unit (BHU). Findings include; 1. Facility policy titled "ELEMENTS OF THE PSYCHOSOCIAL ASSESSMENT" last reviewed/revised 4/15 states under policy on page 1: "Psychosocial Assessments will be completed within 72 hours of admission for length of stay greater than 10 days and 48 hours for length of stay less than 10 days....." 2. Review of inpatient medical records on BHU on 11/10/15 indicated the following: (A) Patient #8 was admitted to the BHU on 11/3/15. The medical record lacked a Psychosocial Assessment. (B) Patient #11 was admitted to the BHU	S 1804	A completion of the Psychosocial Assessment for each patient within: 1.) 72 hours of admission for patients with a length of stay >10 days; and 2.) 48 hours for length of stay less than 10 days will be reviewed with the daily shift chart audit check to ensure completion. If assessment is missing or deficient within 72 hours, the Nurse Manager or Staff Nurse completing the audit will notify the Social Worker to resolve the deficiency. This process began on November 23, 2015. The Director of Inpatient Services will be responsible to ensure these are completed per policy.	11/23/2015

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	151325	A. BUILDING 00 B. WING	11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S WARRICK HOSPITAL, INC	1116 MILLIS AVE BOONVILLE, IN 47601

(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
	on 10/22/15. The medical record lacked a Psychosocial Assessment. 3. Staff member #001 (Licensed Clinical Social Worker) verified in interview beginning at 11:40 a.m. that the Psychosocial Assessments were not completed for patients #8 and #11.			