

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150109	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/15/2015
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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S 0000 Bldg. 00	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 10/13/2015 to 10/15/2015</p> <p>Facility Number: 005096</p> <p>QA: cjl 11/24/15</p>	S 0000		
S 0606 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</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 document review and interview, the hospital's infection control committee failed to determine employee communicable disease history for varicella for five (#P1, #P2, #P4, #P5 and #P6) of ten personnel files reviewed failed to document the communicable disease history for four of ten employees for Rubella and/or Rubeola testing (Rubella: P#4, #P6 and Rubeola: P#2, #P4, #P5). Findings included:</p> <ol style="list-style-type: none"> 1. Review of 5 hospital personnel files indicated no documentation of history of or immunity to varicella for the following employees: #P1, #P2, #P4, #P5 and #P6. 2. On 10/14/15 at 12:10 p.m., employee #8 acknowledged the above missing documentation. 3. Review of 4 hospital personnel files indicated no documentation of Rubella or Rubeola titer testing results for the following employees: Rubella: P#4, #P6 and Rubeola: P#2, #P4, #P5. 	S 0606	<p>Policy review will be completed by 12/31/2015. Responsible Party: Manager of Employee Health. Policy revisions (if indicated) will be completed by 1/31/2016. Responsible Party: Manager of Employee Health. Communicable disease immunization files for the identified deficit area will be reviewed for compliance with guidelines. Completed by 1/31/2016. For any files not meeting compliance, the Employee Health office will ensure notification to the employee, order the testing and collect the specimen/information as appropriate. These steps will be completed within 30 days of identification of noncompliance. Compliance is expected to occur no later than 3/31/2016. Responsible party: Employee Health Manager. A checklist will be utilized to ensure compliance with communicable disease history. Checklists will be used for each new hire following approval of the revised policy. The estimated approval date will be on or before 3/31/2016. Responsible party: Employee Health Manager. Employee Health will provide updates to the Infection Control Committee regarding compliance, at least quarterly. Responsible Party: Employee Health Manager.</p>	03/31/2016

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S 0788 Bldg. 00	<p>4. On 10/14/15 at 12:10 p.m. employee #8 acknowledged the above missing documentation.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(9)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(9) Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be recorded.</p> <p>Based on document review and interview, the facility failed to ensure a properly executed transfer form was in the medical record for 2 of 3 patients transferred from the facility (#N16 and N18).</p> <p>Findings included:</p> <p>1. Review of the facility policy "Transfer Patient to a Non-Franciscan- St. Elizabeth Health Acute Hospital In-Patient Setting Procedure", last revised 06/22/15, indicated, "The plan for</p>	S 0788	Case Management and Nursing Directors will draft a revised policy and procedure. This will be completed by 12/20/2015. The Directors of Nursing and Case Management are the responsible parties. Revised policy and procedure will be presented to the Chief Nursing Officer for review. This will be completed by 12/31/2015. Responsible party: Director of Case Management. Revised policy and procedure will be presented to the Nursing Division leadership. This includes Directors, Managers, and Patient Care Coordinators.	03/31/2016

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	<p>transfer of care of a patient from Franciscan- St. Elizabeth Health to an acute hospital in-patient setting for an emergent or non-emergent condition shall be the responsibility of the department where the patient event occurs. ... B. The Nursing Supervisor needs to be notified of the transfer and the receiving hospital should be contacted and informed of the need for transfer and the name of the accepting physician. The hospital should verify their acceptance or if patient has to be placed on a waiting list. ... D. The form entitled 'Patient Assessment, Certification, and Consent to Transfer' should be completed for ambulance transfer and signed by those indicated on form."</p> <p>2. Medical record #N16 indicated the patient was admitted to the facility on 07/22/15 and was transferred by ambulance to another facility for specialty care on 07/25/15. The record contained the form "Patient Assessment, Certification, and Consent to Transfer", but lacked documentation on the form of the receiving physician, report given and time, and a signature of the patient or representative indicating consent to transfer. The record also lacked any documentation of the patient being unable to sign or any telephone/verbal consent.</p>		<p>This will be completed by 1/31/2016. Responsible Party: Director of Nursing. Computer based training will be developed and required by all nursing staff to completed. The training will be developed by 1/31/2016. Responsible party: Director of Clinical Education. Reports will be developed to track all acute-to-acute transfers. This will be completed by 1/31/2016. Responsible party: Manager of Clinical Information Services. Nursing Quality Council will review 100% of all acute transfers for compliance on a monthly basis until > 95% compliance is reached. Then monthly reviews will be a random selection of 30 cases to monitor for continued compliance. The review of 100% charts will begin 2/1/2016 with ongoing monthly reviews.</p>				

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S 0912 Bldg. 00	<p>3. Medical record #N18 indicated the patient was admitted to the facility on 08/26/15 and was transferred by ambulance to another facility for specialty care on 08/28/15. The record lacked the form "Patient Assessment, Certification, and Consent to Transfer".</p> <p>4. At 2:15 PM on 10/15/15, staff member A6, the Director of Nursing Operations, confirmed the lack of documentation on the transfer form for patient #N16 and the lack of the transfer form for patient #N18.</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> <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</p>			

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	<p>areas of the hospital.</p> <p>(ii) Maintaining a current nursing service organization chart.</p> <p>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.</p> <p>(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.</p> <p>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and interview, the nurse executive failed to ensure pain assessments and reassessments were done according to policy and protocol for 3 of 4 pediatric patients treated in the Emergency Department (ED) (#N1, #N2, and #N5).</p> <p>Findings included:</p> <p>1. Review of the facility policy "Pain Management Procedure", last revised 04/02/14, indicated, "A. All patients have the right to appropriate pain assessment and management of pain. ... Alternate pain intensity assessment systems that may be used ... are: ... 5. FLACC (face, legs, activity, cry, consolability) pain scale- recommended to be used for preverbal or mentally</p>	S 0912	<p>Pain assessment reminders have been placed in each Emergency Department (ED) patient care room for staff reference. This includes the FACES chart for the pediatric population. This was completed 12/7/2015.</p> <p>Responsible party: Director of ED. Computer based training (CBT) related to pediatric pain assessment/reassessment in the ED will be developed. This will be completed by 12/31/2015.</p> <p>Responsible party: Director of ED. CBT will be reviewed, approved, and assigned to all ED registered nurse staff. Completion of the CBT by staff will be completed by 2/28/2016.</p> <p>Responsible Parties: Director of Clinical Education and Director of ED. A chart audit tool will be developed and utilized for monthly chart reviews to ensure compliance. This will be</p>	03/31/2016

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	<p>delayed patients, most typically young children from infancy to 7 years. ... Procedure: A. Every patient is screened for pain upon admission by a licensed nurse using a hospital approved pain scale to achieve a comfort function goal. B. A complete pain assessment will be performed: ... - within 1 hour of pain management intervention or as patient's condition warrants."</p> <p>2. Medical record #N1 indicated a 14-month old arrived at the ED at 1316 hours on 07/15/15 due to facial swelling. The patient was seen, treated, and left the ED at 1657 hours for the Pediatric Unit. The record lacked documentation of any pain assessment in the areas provided in the ED record.</p> <p>3. Medical record #N2 indicated a 21-month old arrived at the ED at 1740 hours on 08/25/15 due to fever, vomiting, and diarrhea. The patient was given Advil at 1829 hours, but the record lacked documentation of the reason for the medication or any reassessment. The patient left the ED at 2100 hours for the Pediatric Unit and the record lacked documentation of any pain assessment in the areas provided in the ED record.</p> <p>4. Medical record #N5 indicated a 12-day old arrived at the ED at 1044</p>		<p>completed by 3/31/2016. Responsible Party: Director of ED. Chart reviews will occur monthly with a minimum of one chart per day. These will continue until > 90% compliance rate is reached. Monthly audits will then shift to quarterly audits. Routine audits will cease with the achievement of >90% compliance for at least 2 months.</p>				

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S 0952 Bldg. 00	<p>hours on 08/02/15 due to a high fever. The patient underwent three unsuccessful attempts for a lumbar puncture before he/she was admitted to the Pediatric Unit at 1348 hours. The record lacked documentation of any pain assessment in the areas provided in the ED record.</p> <p>5. At 3:30 PM on 10/14/15, staff members A1, the Performance Improvement Nurse Coordinator, A6, the Director of Nursing Operations, and A31, Informatics Nurse Manager, confirmed the lack of any ED pain assessments for the pediatric patients.</p> <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).</p> <p>Based on document review and interview, the hospital failed to administer blood transfusions in accordance with approved</p>	S 0952	Blood Administration PI team convened. This will be completed by 11/9/2015. Responsible Party: Director of Nursing Operations.Educational module	03/31/2016

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	<p>medical staff policies and procedure for four of twenty patients (Patient #1, Patient #4, Patient #9 and Patient #15).</p> <p>Finding(s) include:</p> <p>1. The policy, "Blood Products Transfusion and Management Procedure", procedure #: 6101-II-1213, reviewed 8/21/15, read: "Intra-Transfusion vital signs (temperature, pulse, and blood pressure) and Intra-Transfusion assessment are to be recorded after the blood product has been transfusing for 15 minutes (+ or - 5 minutes)."</p> <p>2. In review of four patients receiving four blood units, four of these received-units did not have complete documentation, per policy, on the Transfusion Details record form including:</p> <p>Patient #1 Unit 1b, was administered on 8/01/15 at 8:06 p.m.: The 15</p>		<p>required of all nurses. This will be completed by 11/30/2015. Responsible Party: Director of Nursing Operations. Epic Blood Product Administration Instructions sent with each unit. This will be completed by 11/30/2015. Responsible Party: Director of Nursing Operations. Documentation checklist to assist with following proper sequence and documentation developed and shared with staff. This will be completed by 11/30/2015. Responsible Party: Director of Nursing Operations. Printing of Transfusion form from electronic record required and attached to above checklist. This will be completed by 11/30/2015. Responsible Party: Director of Nursing Operations. 100% Record Review Process being completed using a transfusion checklist and double check for all documentation and adherence to policy required with both RN hanging blood and charge nurse signing form and submitting to the Department Director. This will be completed by 11/30/2015. Responsible Party: Directors of each clinical unit. Tip sheet developed to remind staff of process for correcting Epic Documentation if needed. This will be completed by 11/30/2015. Responsible Party: Manager of Nursing Informatics. Charge nurse education: paper/electronic documentation double check for</p>	

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	<p>minute vitals were documented at 8:27 p.m. which was 21 minutes (1 minute late) in lieu of within +/- 5 minutes (10-20 minutes).</p> <p>Patient #4 Unit 4a, was administered on 8/04/15 at 8:29 a.m.: The 15 minute vitals were documented at 8:51 a.m. which was 22 minutes (2 minute late) in lieu of within +/- 5 minutes (10-20 minutes).</p> <p>Patient #9 Unit 9a, was administered on 8/17/15 at 9:48 a.m.: The 15 minute vitals were documented at 10:11 a.m. which was 23 minutes (3 minute late) in lieu of within +/- 5 minutes (10-20 minutes).</p> <p>Patient #15 Unit 15a, was administered on 8/25/15 at 12:39 p.m.: The 15 minute vitals were documented at 1:00 p.m. which was 21</p>		<p>accuracy, electronic documentation revision process. This will be completed by 11/30/2015. Responsible Party: Manager of Nursing Informatics. Corporate Epic Process Improvement project to implement serial improvements throughout 2016. This kick-off will occur by 1/31/2016. Responsible Party: Manager of Nursing Informatics. System Improvements - Changes to administration window in Epic to promote complete pre-transfusion documentation. This was completed in April 2015. Responsible Party: Manager of Nursing Informatics. Best Practice Alert created to notify nurses when they attempt to inadvertently document against the incorrect unit number. This will be completed by 12/31/2015. Responsible Party: Manager of Nursing Informatics. Electronic Compliance report is being drafted by report writers assist with monitoring of documentation compliance. This will be completed by 1/31/2016. Responsible Party: Manager of Nursing Informatics. Two barcodes on blood bag need scanned into the system and lab will label each 1 and 2 so staff scan them in the correct order. This will be completed by 1/31/2016. Responsible Party: Blood Bank Supervisor. Weekly transfusion unit activity reports run by lab and sent to each</p>		

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S 1118 Bldg. 00	<p>minutes (1 minute late) in lieu of within +/- 5 minutes (10-20 minutes).</p> <p>3. On 10/14/15 at 9:45 a.m., staff member #31 acknowledged that the two above-listed patient blood units had incorrect or incomplete documentation, per policy.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based upon observation, document review and interview, the kitchen had maintained a condition in one of four kitchen work areas which may present a hazard for employees, failed to maintain the</p>	S 1118	<p>Department Director to reconcile with the checklist. This will be completed by 12/31/2015. Responsible Party: Blood Bank Supervisor. Lab will provide a triple check to 10% or 30 transfusions monthly. This will be started by 12/31/2015. Responsible Party: Blood Bank Supervisor.</p> <p>Cylinders were secured by existing chains on 10/13/2015. Food and Nutrition staff began daily checks on 11/1/2015. Daily checks will continued for six (6) months. Responsible Party: Director of Food and Nutrition Services. The non-dated eyewash station solutions were replaced 10/14/2015. Staff education</p>	04/30/2016

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	<p>hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in #F2 offsite power plant and failed to ensure a safe environment for patients by following their policy and standards of practice regarding warming cabinets in eight instances.</p> <p>Findings include:</p> <p>1. On 10/13/15 at 12:45 p.m., it was observed that the Heartland Perks Cafe back work area contained an unchained gas cylinder used for dispensing beverages. This cylinder presented a potential physical hazard in the event it fell over and harmed an employee in its path.</p> <p>2. On 10/13/15 at 1:00 p.m., staff member #20 acknowledged that the above-listed cylinder was unchained.</p> <p>3. Review of Franciscan Alliance Emergency Eye Wash Station/Showers Procedure policy (last reviewed</p>		<p>related to required dating of installation dates was completed by 11/30/2015. Routine inspections will occur. Responsible Party: Maintenance Supervisor. Eye wash station in the Boiler Room was replaced and weekly inspections started. This occurred by 10/31/2015. Staff duties have been realigned to ensure compliance. Responsible Party: Maintenance Supervisor. Warming Devices: Policy revised to indicate maximum temp of 130 for blankets, and 104 for IV solutions and irrigation fluids by Research Council. This was completed by 11/6/2015. Responsible Party: Director of Nursing Operations. Presented to Synergy Council for approval. Approved pending minor revisions. This was completed by 12/2/2015. Responsible Party: Director of Nursing Operations. Final revision to policy completed. This was completed by 12/9/2015. Responsible Party: Director of Nursing Operations. Graphic form for documenting temperatures revised. This was completed by 12/8/2015. Responsible Party: Director of Nursing Operations. Computer Based Training (CBT) development complete. This will be completed by 1/31/2016. Responsible Party: Director of Nursing Operations. CBT launched and required of all</p>				

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905		
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	<p>2/5/2015) indicated self-contained units are visually examined weekly. Bottles must be changed every 6 months regardless of date on bottle. Emergency Eye Wash Stations and Showers are part of the safety program for eye and chemical exposure safety as stated per American National Standards Institute (ANSI).</p> <p>4. During the tour of #F2 offsite power plant at 10:25 AM on 10/14/2015, the eye wash station located in the Boiler Room had a white manufacturer's tag hanging from the cartridge on the self-contained unit. The manufacturer's tag on the self-contained unit indicated the cartridges of water are to be checked visually every week and the cartridges are to be replaced every 6 months. The last weekly inspection date recorded on the tag was documented January 2014.</p> <p>5. In interview at 3:25 PM on 10/14/2015, staff member #21 (Director of Engineering) indicated the self-contained eye wash stations are not visually checked weekly and the water cartridges are not replaced every 6-months as required by the manufacturer.</p> <p>6. During the tour of the 3 North Unit at 11:00 AM on 10/13/15, accompanied by</p>		<p>staff in areas that utilize warmers, 30 days to complete. This will be completed by 2/28/2015. Responsible Party: Director of Nursing Operations. Each Department Director will monitor that staff are checking temps daily, appropriately implementing action plans if temp not in range, checking for IV fluid expirations dates and turn in their compliance monthly to Quality Council. This will begin 2/1/2016. Responsible Party: Director of Nursing Operations. Nursing Quality Council members will spot check warmers quarterly. This will begin 2/28/2016. Responsible Party: Director of Nursing Operations.</p>		

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>staff members A6, the Director of Nursing Operations, and A11, the Unit Director, a Steris warming cabinet containing blankets was observed registering 150 degrees Fahrenheit (F). A tape on the cabinet indicated the warmer temperature range was 90 to 160 degrees F. The log with the warmer indicated the daily temperatures for the current month were between 156 and 159 degrees F.</p> <p>7. At 11:00 AM on 10/13/15, staff member A6 indicated the temperature range was based on the manufacturer's guidelines.</p> <p>8. During the tour of the 3 South Unit at 11:35 AM on 10/13/15, accompanied by staff members A6, A12, the Unit Director, and A13, the Patient Care Coordinator (PCC), a Steris warming cabinet containing blankets was observed registering 150 degrees F.</p> <p>9. During the tour of the Intensive Care Unit at 11:50 AM on 10/13/15, accompanied by staffs A6 and A14, the Unit Director, a Steris warming cabinet containing blankets was observed registering 151 degrees F.</p> <p>10. During the tour of the Emergency Department (ED) at 9:00 AM on 10/14/15, accompanied by staff members</p>			

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>A6, A24, the ED Director, and A25, the ED Patient Care Coordinator, a Steris warming unit containing linens was observed registering 160 degrees F. The monitoring logs for the two other warmers in the department also indicated the temperatures were consistently 160 degrees F. or above.</p> <p>11. During the tour of the Obstetrical Department at 10:00 AM on 10/14/15, accompanied by staff members A27, the Clinical Resource Nurse and A28, the Patient Care Coordinator, a Steris warming unit was observed in the substerile area. The top chamber registered 100 degrees F. and contained fluids and the bottom chamber registered 125 degrees F. and contained linens. Two of eight bags of Lactated Ringers intravenous fluids (IVs) were observed in the top chamber, one dated 10/29/15 and one dated 10/30/15, over 14 days.</p> <p>12. At 10:10 AM on 10/14/15, staff member A27 indicated the fluids could only be in the warmer for 14 days and were to be dated with the expiration date when placed in the warmer. He/she confirmed the bags were not dated correctly.</p> <p>13. During the tour of the Out-Patient Surgical Unit at 10:40 AM on 10/14/15,</p>			

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>accompanied by staff members A6 and A26, the Director of the unit, a Steris warming unit was observed in the holding bay. The top chamber registered 100 degrees F. and contained fluids and the bottom chamber registered 124 degrees F. and contained linens. Two of six bags of 0.9 % Normal Saline IV solution were observed in the top chamber with a date of "10/12" marked out and "10/19" written over on the outer wrap. Another bag of 0.9 % Normal Saline IV solution was observed with an expiration date of "10/12" written on the outer wrap. One bag of Lactated Ringers solution with an attached tubing, not in the overwrap, was also observed in the top chamber with no date marking. Another warmer containing only linens was observed in the hallway. The unit had two chambers, but the monitoring log only had one temperature documented daily which was 156 to 158 degrees F.</p> <p>14. During the tour of the Wound Care Center at 9:10 AM on 10/15/15, accompanied by staff members A2, the Director of Nursing Operations, A5, the Chief Nursing Officer, and A34, the Unit Director, a Steris warming unit containing blankets was observed registering 155 degrees in the hallway.</p> <p>15. During the tour of the Radiology</p>			

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>Department at 1:30 PM on 10/15/15, accompanied by staff members A6 and A39, the Imaging Manager, a Steris warming unit containing blankets was observed registering 156 degrees F. in the nursing area.</p> <p>16. Review of the facility policy "Warming Cabinets for Blankets and Solutions Monitoring & Cleaning Procedure", last reviewed 09/29/15, indicated, "The purpose of the policy is to create a safe environment for our patients by decreasing the likelihood of extreme temperatures when administering fluids and/or injury. ... Procedure: ...B. Blanket warming cabinets will be maintained within the recommended temperatures of the manufacturer. C. IV solution warmers will be maintained within the recommended temperatures of the solution manufacturer. D. All types of warming device temperatures will be recorded on the attached temperature log sheet. ... II. Documentation: A. A warming cabinet temperature log form will be used to record temperatures daily for each warming cabinet in patient care areas. B. Each Department Manager/Director is responsible for any warming cabinet within their department."</p> <p>17. Review of the facility policy</p>			

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>"Warming of Fluids, Medications, and Contrast Media Procedure", last revised 01/24/14, indicated, "Procedure: A. Baxter IV solutions of volumes 150 ml. [milliliter] or greater in plastic overpouches may be stored in a warmer not exceeding 40 degrees Celsius or 104 degrees Fahrenheit for a period no longer than 14 days. ... D. Personnel placing these items in a warmer are responsible for documenting the expiration date and time on the containers prior to placing them in a warmer. A permanent marking pen may be used to mark the date/time on the overpouches of IV or irrigation solutions in bags. ... The date/time should not be written directly on the plastic IV bags or plastic portion of irrigation bottles. E. The warmer should be checked daily and any IV solutions or irrigation solutions remaining in the warmer for greater than the time periods specified in this policy should be removed and discarded."</p> <p>18. Review of the manufacturer's literature for the Steris warming unit, presented by staff member A6, indicated "Temperature selection range is 90- 160 degrees F. (32.2- 71.1 degrees C.)". The manufacturer's literature did not indicate any recommended temperatures for fluids or blankets.</p>			

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S 1125 Bldg. 00	<p>19. At 4:00 PM on 10/14/15, staff member A6 confirmed the inconsistencies with the temperatures, logs, dating, and monitoring of the warming units. He/she confirmed the facility followed AORN (Association of periOperative Nurses) guidelines which indicated warming temperatures for blankets or other patient linens should not exceed 130 degrees F. The guidelines also indicated solutions, blankets, and patient linens should be stored in separate warming cabinets or in separate compartments with independent temperature controls and temperatures should be set, maintained, monitored, and documented according to organizational policy.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(B)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the</p>			

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>physical plant and equipment by qualified personnel as follows:</p> <p>(B) Operational and maintenance control records shall be established and analyzed periodically. These records shall be readily available on the premises.</p> <p>Based on document review, observation, and interview, the hospital failed to post the boiler certificates of compliance near the boilers located in Franciscan St. Elizabeth Health-Lafayette East hospital and #F2 off-site hospital.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Indiana Administrative Code, 680 IAC 2-3-14, indicated that Boiler certificates shall be posted under glass in the room containing the vessels. The certificate posting requirement was also listed on the boiler certificates. 2. During the tour of #F2 offsite power plant at 10:32 AM on 10/14/2015, the boiler room was observed without the boiler certificates of compliance posted. 3. During the tour of Franciscan St. Elizabeth Health-Lafayette East power plant at 1:45 PM on 10/14/2015, the boiler room was observed without the boiler certificates of compliance posted. 	S 1125	<p>Certificates have been mounted as of 10/15/2015 in the boiler room with appropriate glass coverage. A mount more protective from sunlight/heat/splashes will be obtained and mounted by 12/31/2015. Responsible Party: Maintenance Supervisor.</p>	12/31/2015

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S 1164 Bldg. 00	<p>4. In interview at 2:00 PM on 10/14/2015, staff member #21 (Director of Engineering) indicated the certificates to the boilers for Franciscan St. Elizabeth Health-Lafayette East and #F2 hospitals were in the offices on the desk and a few were in the file drawers.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the hospital failed to conduct preventive maintenance on the 2 floor scrubbers, 2 overhead operating room swing lights, 1 patient care therapy steps and 4 wheelchairs.</p>	S 1164	Preventative Maintenance:The Medical Equipment Management Program Preventative Management will be revised to indicate clear lines of responsibility for Clinical Engineering and Physical Plant Engineering in relationship to medical equipment. Approval of	12/31/2015

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>Findings include:</p> <ol style="list-style-type: none"> In review of Franciscan Alliance Medical Equipment Management Program (MEMP) - Overview Procedure (last reviewed 1/16/2013) indicated all medical equipment is assessed and inspected prior to use. The clinical engineering staff evaluates the medical equipment to establish a subsequent inspection frequency. The MEMP does not pertain to patient or office appliances or other fixed and portable electrically powered equipment as may be used to provide environmental, administrative or business functions. The Engineering Department would be responsible for these pieces of equipment. In review of Franciscan Alliance Preventive Maintenance Procedure (last reviewed 6/13/2013) indicated all patient care equipment, environmental, industrial, and office equipment that are not schedule for preventive maintenance inspections by the Clinical Engineering Department; shall be scheduled through the Engineering Department routine preventive maintenance work orders. In review of the preventive maintenance documentation for 2 floor scrubbers, 2 overhead operating room swing lights, 1 patient care therapy steps 		<p>the policy revision will occur by 12/31/2015. Weekly meetings to discuss preventative maintenance issues began 12/4/2015 and will be ongoing. Barriers for completing preventative maintenance will be addressed and reviewed by the Safety Committee at the scheduled quarterly meetings. Responsible Party: Directors of Engineering and Clinical Engineering. Floor Scrubbers: A preventative maintenance prompt has been added to the database and are based on manufacturers recommendations. This was completed by 10/31/2015. Monitoring will be included the current monthly preventative maintenance review process. Responsible Party: Director of Engineering.</p>	

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S 1186 Bldg. 00	<p>and 4 wheelchairs, the documentation provided by the hospital confirmed the 9 pieces of equipment were not scheduled or had a preventive maintenance inspection conducted on them.</p> <p>4. In interview at 3:05 PM on 10/14/2015, staff member #21 (Director of Engineering) indicated the 2 floor scrubbers, 2 overhead operating room swing lights, 1 patient care therapy steps, and 4 wheelchairs did not receive preventive maintenance inspections.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(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:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that</p>			

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>contains provisions for the following:</p> <ul style="list-style-type: none"> (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. <p>Based on document review, observation, and interview, the hospital failed to ensure fire drills are conducted per policy for Franciscan St. Elizabeth Health-Lafayette East hospital and 3 offsite locations.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. In review of Franciscan Alliance Fire Control Management Plan (last reviewed 5/7/2015) indicated the facilities have quarterly fire drills that are conducted by Engineering and Security. The fire drills are conducted on all shifts and are conducted in all buildings where patients are treated and housed. In non patient care areas drills are conducted at least annually. 2. In review of the last complete 4 quarters of Franciscan St. Elizabeth Health-Lafayette East, the first and third quarter of 2015 did not provide documented fire drills on the third shift. 3. In review of the last complete 4 	S 1186	<p>All drills were completed by 11/20/2015. Documentation attached for review. A new fire drill schedule for 2016 has been developed and is attached for review. Drills will be conducted to include second and third shifts where applicable. First shift drills will be conducted between 0700 and 1700. Responsible Party: Administrative Director of Support Services and Facility Management.</p>	11/20/2015

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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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	<p>quarters of #F2 off-site, the fourth quarter of 2014 and second quarter of 2015 did not provide documented fire drills on the third shift.</p> <p>4. In review of 11 off-site locations that are required to conduct annual fire drills, two of the eleven off-sites did not provide documented fire drills for 2014: #F3 and #F4.</p> <p>5. In interview at 2:15 PM on 10/14/2015, staff member #30 (Security Director) confirmed that he/she could not provide 2014 annual fire drill for Kathryn Weil Center and Lafayette Breast Center offsites. The staff member confirmed the Franciscan St. Elizabeth Health-Lafayette East hospital and Franciscan St. Elizabeth Central Hospital off-site had third shift fire drills missing.</p>			