

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150057	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/02/2015
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NAME OF PROVIDER OR SUPPLIER  FRANCISCAN ST FRANCIS HEALTH - MOORESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HADLEY RD MOORESVILLE, IN 46158
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S 0000  Bldg. 00	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 8/31/2015 through 9/2/2015</p> <p>Facility Number: 005052</p> <p>QA: cjl 09/15/15</p>	S 0000		
S 0178  Bldg. 00	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and staff interview, the hospital failed to ensure the hospital license was conspicuously posted for patient viewing at the Franciscan St. Francis Health - Franklin Infusion offsite.</p> <p>Findings included:</p>	S 0178	<p>S 178.2 The Indiana State Department of Health Hospital License was placed in the waiting room at the Franklin Office on the day of survey (9/1/15.) Refer to attachment S 178 A.</p> <p>Responsible Person: Franklin Infusion Manager Deficiency Corrected on 9/1/15</p>	09/02/2015

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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S 0554 Bldg. 00	<p>1. At 9:10 AM on 9/1/2015, the Franciscan St. Francis Health - Franklin Infusion offsite was observed without a copy of the Indiana State Hospital License posted at the entrance or in the lobby of the building for the patients and visitors to view.</p> <p>2. At 9:15 AM on 9/1/2015, staff member #16 (Franklin Infusion offsite Director) confirmed the offsite does not have a copy of the hospital license posted for visitors to view.</p> <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> <p>Based on document review, observation and interview, the facility failed to follow its infection control policy and manufacturer's recommendations regarding the cleaning of Accu-Chek glucose monitors' charging and transmission bases, risking infection transmission from one patient to another.</p>	S 0554	S 554  1. Signs will be posted with each Accu-chek machine to remind staff of requirement to clean the meter and the housing between each patient use. Units to	09/28/2015

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>Hospital Policy #1262528, Hospital Wide Infection Prevention Policy for Cleaning, Disinfection and Sterilization of Patient Care Items, last reviewed 3/20/2014, indicated patient care devices will be handled/processed to ensure sterility/cleanliness in order to minimize the risk of infections. The method of processing a given item/device will depend on its intended use.</li> <li>The manufacturer's recommendations regarding cleaning the Accu-Chek machine indicated that the meter and its housing be thoroughly cleaned and disinfected between each use.</li> <li>Observations:               <ol style="list-style-type: none"> <li>While touring the Intensive Care Unit (ICU) on 8/31/2015, at 1330 hours, accompanied by staff member #3, Manager of Nursing Practice, it was noted that the two Accu-Chek bases appeared to have small amounts of dust and debris in them.</li> <li>While touring the Medical-Surgical-Orthopedics Units (which share a nurse station) on 9/1/2015 at 0900 hours, accompanied by staff member #3, it was noted that the two bases for the Accu-Cheks appeared to</li> </ol> </li> </ol>		<p>include Medical Surgical, Orthopedics, Obstetrics, Emergency Services, and Perioperative Services. (See Attachment S 554 A)</p> <p>Responsible Person: Director of Patient Care Services</p> <p>Completed 9/28/15</p> <p>2. Verbal reminders of the importance of cleaning both the meter and the housing will be given at upcoming staff meetings by the Director of Patient Care Services.</p> <p><b>Medical Surgical &amp; Orthopedics:</b> September 28 and 30, 2015</p> <p>Responsible Person: Director of Patient Care Services</p> <p>Completion Date: 9-28/9-30-15</p> <p><b>Obstetrics:</b> September 28, 2015</p>	

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	<p>have small amounts of dust and debris in them.</p> <p>4. Staff member #3 concurred with these findings.</p>		<p><b>Responsible Person:</b> Director of Patient Care Services</p> <p>Completion Date: 9-28-15</p> <p><b>Emergency Services:</b> October 5, 2015</p> <p>Responsible Person: Director of Patient Care Services</p> <p>Completion Date: 10-5-15</p> <p><b>Perioperative Services:</b> Meeting prior to October 31, 2015</p> <p>Responsible Person: Director of Patient Care Services</p> <p>Completion Date: By October 31, 2015</p> <p><b>ICU:</b> Next scheduled meeting is November so will communicate via weekly unit newsletter from Manager on October 2, 2015</p>	

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S 0598	410 IAC 15-1.5-2 INFECTION CONTROL		<p>Responsible Person: ICU Manager</p> <p>To be completed 10-2-15</p> <p>3. Observations:</p> <p>In order to assure compliance, the manager of each unit will submit a completed audit form monthly to the Director of Patient Care Services. The audit is to be completed during the last week of each month and will include direct observation of each Accu-chek unit for cleanliness. (See attachment S 554 B.) Audits to begin October, 2015.</p> <p>Responsible Person(s): Unit Managers and Director of Patient Care Services</p> <p>Completion Date: Audits to begin in October, 2015</p>	

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Bldg. 00	<p>410 IAC 15-1.5-2(f)(3)(D)(iv)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control 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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on document review, observation and staff interview, the facility failed to ensure the Occupational Therapy Department was complying with FDA (Food and Drug Administration) requirements on not refilling ultrasound gel containers.</p> <p>Findings included:</p> <p>1. FDA indicates ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. However, past studies have demonstrated that ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA</p>	S 0598	<p>S 598 1-3Once an ultrasound gel container is emptied, it will be discarded and replaced with a new container.All gel bottles were removed from the Occupational Therapy Department on day of survey 9/1/15 and replaced with in stock new ultra sound containers. PolicyStat ID: 1834900 has been updated to reflect this process (attachment S- 598 A-Ultra Sound Policy page 2, item 2)Responsible Person(s):Rehabilitation Department Technician is responsible for ordering ultra sound gel and disposing of the emptied containers. Rehabilitation Manager is responsible for oversight of process and compliance.Deficiency corrected on 9/1/15.</p>	09/02/2015
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S 0612 Bldg. 00	<p>recommends that ultrasound gel containers not be refilled.</p> <p>2. At 3:25 PM on 9/1/2015, the Occupational Therapy Department ultrasound station was inspected. Located in the room was a wheeled cart with 16-ounce ultrasound gel containers inside a warming unit on top shelf and a partial bulk plastic container of Aquasonic Ultrasound Gel on a lower shelf.</p> <p>3. At 3:27 PM on 9/1/2015, staff member #19 (Occupational Therapy Manager) indicated he/she refills the ultrasound gel plastic bottles. The staff member indicated a box containing 1 empty plastic bottle and a bulk plastic container of Aquasonic Ultrasound Gel. The empty plastic container would be refilled several times with the bulk container of ultrasound gel until it is empty.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows:</p>			

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	<p>(3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling. Based on document review, observation and staff interview, the infection control committee failed to ensure an effective means of destroying microorganisms while using the washer and dryer located in the Environmental Service (EVS) Department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Franciscan St. Francis Health - Mooresville Sleep Lab Linen policy (last reviewed 5/1/2015) indicated linen is washed in cold water cycle to loosen stains and use with bleach (160 to 180 degrees Fahrenheit).</li> <li>CDC guidelines for laundry services in health care facilities states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for</li> </ol>	S 0612	<p><b>S612</b></p> <p><b>Plan of Correction:</b></p> <ol style="list-style-type: none"> <li>The deficiency of scrubs, mops, and rags being laundered at temperatures below 160° for a duration of more than 25 minutes is in the process of being corrected. As per the attached service report from Laundry Services (see attachment S612 A), the laundry machines have been verified for proper factory recommended operation. As per attached work order (see attachment S612 B) and material invoices (see attachment S612 C), the inlet water temperature is being modified to 160° plus. The inlet temperature modification will be complete by October 9, 2015. Upon completion of the temperature modifications, a factory service technician will verify an operating temperature above 160° for a duration in excess of 25 minutes. The factory authorized service will be complete by October 16, 2015.</li> </ol>	10/01/2015

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	<p>hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled at a residual of 50-150 ppm (parts per million) during the chlorine bleach cycle."</p> <p>3. The 9/1/2015 Franciscan St. Francis Health Mooresville Campus Laundry-Special Linen Temperature log for September 1, 2015 indicated OB (obstetrics) scrubs were washed without bleach and the washer water temperature was 99 degrees Fahrenheit.</p> <p>4. At 3:40 PM on 9/1/2015, the clean linen and soiled linen storage rooms were toured. The clean linen room had covered carts of clean laundry and 2 industrial dryers. One dryer had dried gowns in it. The soiled linen holding room contained two industrial washers. One washer had blue gowns in it. The in-house laundry care program was posted on the wall located in the soiled linen room. The washer was set up for 8 different washing cycles. Each cycle had different washing calibrations of the fabric that can be washed. The eight cycles are: Rinse &amp; Extract; Microfiber</p>		<p>2. The hospital policy for the laundering of mops and rags will be modified before October 9, 2015 to include a laundering cycle of not less than 25 minutes. Find attached the hospital infection control policy defining a laundering cycle of 25 minutes or more for linens. (See attachment S612 D)</p> <p>3. The responsibility for laundering of OB hospital scrubs will be transferred from the Mooresville Laundry Department to United Hospital Services before January 1, 2016.</p> <p>4. Deficiency reoccurrence will be prevented by implementing a modified quality control log sheet in the laundry area. Find attached a sample log sheet from August 2015 for the hospital laundry. (See attachment S612 E) The log sheet currently includes temperatures and chemicals and will be modified to also include cycle duration and corrective action if temperatures, chemicals, or cycle duration fall below policy requirements.</p> <p>Responsible Person(s): Director of Environmental Services</p> <p>Deficiency corrected on 10-1-15</p>	

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	<p>&amp; Isolation Gowns; Gowns (No Bleach); Scrubs (No Bleach; Sheets &amp; Pillow cases (Mostly Bleach); Blankets &amp; Towels; Baby Items &amp; Blue Towels; and Mops.</p> <p>5. At 3:45 PM on 9/1/2015, staff member #18 (EVS Manager) indicated the washers only heat the water up to 115 degrees Fahrenheit and the industrial dryers hot temperature heats to 120 degrees Fahrenheit. The water temperature was recorded on every load the washers do. Bleach was not used on scrubs. Mops and rags are also washed and they are used in patient care areas also. Bleach was not used for mops and rags. The water temperature for mops and rags reaches 105 degrees Fahrenheit respectively. The in-house washer and dryer service for the hospital was not monitored and evaluated as part of the quality improvement program. The staff member indicated he/she did not know the CDC requirements of proper washing and drying healthcare laundry and linen. The staff member indicated the only hospital policy on in-house laundry services was for sleep lab linen. The staff member indicated he/she does not monitor the laundry service for effective disinfecting of pathogens that are on the line that were being washed and dried.</p>			

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S 0952 Bldg. 00	<p>6. At 11:20 AM on 9/2/2015, staff member #4 (Engineering Director) indicated that he/she did not know the CDC guidelines for proper washing and drying of healthcare laundry. The staff member indicated the in-house laundry service was not monitored through the quality improvement program.</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). Based on policy procedure review, transfusion record review, and staff interview the facility failed to follow approved medical staff policies/procedures for 2 of 6 blood</p>	S 0952	<p>S952</p> <p>1.All nursing staff have completed annual competency related to blood transfusion administration and documentation for 2014- 2015. (See</p>	10/31/2015

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	<p>transfusions reviewed.</p> <p>Findings include:</p> <p>1. On 8/31/15 review of a policy/procedure titled, "ADMINISTRATION of BLOOD and BLOOD COMPONENTS POLICY" stated the following: "E. ADMINISTERING BLOOD AND BLOOD COMPONENTS 9. Record in the electronic record and on the Transfusion Record the date and time and obtain and document the patient's temperature and vital signs prior to spiking the blood. 14. Document the date and time of initiation of transfusion. 17. Vital signs must be assessed and documented 15 to 25 minutes after initiation of the transfusion. 20. On the Transfusion Record, record the ending vital signs and time the transfusion was completed."</p> <p>2. On 9/1/15 review of:</p> <p>a. T#3 given on 4/1/15 to patient AE302368 indicated a start time of 1016 with a 15 to 25 minute post time of 1013.</p> <p>b. T#5 given on 6/1/15 to patient AE1954144 indicated a start time of 1340 and a 15 to 25 minute post time of 1340.</p> <p>3. In interview on 9/1/15 SP(Staff Person)#2 acknowledged approved medical staff policy/procedures were not followed for T#3 and T#5.</p>		<p>Attachment S 952 A)</p> <p>Responsible Person: Each Nursing Manager</p> <p>Completion Date: 9/1/15</p> <p>1. The next annual nursing blood transfusion competency will be rolled out for 4th Quarter of 2015. All nursing staff will be required to complete. This competency will include specifics regarding timing and documentation of steps according to policy.</p> <p>Responsible Person: Each Nursing Manager</p> <p>Corrected Date: December 31, 2015</p> <p>1. Nursing staff will be reminded of the importance of correct timing with blood transfusions, specifically that there must be at a minimum 5 distinct times and that these times should reflect proper procedure:</p> <p>Pre-transfusion vital signs (prior to spiking the bag)</p> <p>Transfusion start time (when blood hits the hub)</p> <p>15 minute vital signs</p> <p>End time</p> <p>Post transfusion vital signs</p> <p>This will be done by the Director of Patient Care Services at the following meetings:</p> <p><b>Medical Surgical &amp; Orthopedics:</b> September 28 &amp; 30, 2015 (Deficiency corrected 9-28/9-30-15) Responsible Person: Director of Patient Care Services</p> <p><b>Obstetrics:</b> September 28, 2015 (Deficiency corrected 9-28-15)</p>				

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			<p>Responsible Person: Director of Patient Care Services</p> <p><b>Emergency Services:</b> October 5, 2015 (Deficiency to be corrected by 10-5-15) Responsible Person: Director of Patient Care Services</p> <p><b>Peri-operative Services:</b> Deficiency to be corrected by 10-31-15 Responsible Person: Director of Patient Care Services.</p> <p><b>ICU:</b> Next scheduled meeting is November, so will communicate via weekly unit newsletter from Manager on October 2, 2015 (Deficiency to be corrected by 10-2-15) Responsible Person: Manager</p> <p>1.A poster shall be place in all nursing staff break rooms reminding staff of this information (See Attachment S 952 B) Responsible Person(s): Director of Patient Care Services Deficiency corrected 9-29-15</p> <p>1.All paper transfusion records shall be reviewed by a 2nd individual within the department for accuracy, adherence to policy and completeness prior to return of records to the lab. The second reviewer will initial that record has</p>	

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			<p>been reviewed prior to returning record to lab.</p> <p>Responsible Person(s): Each Nursing Manager Process to begin Monday October 5, 2015 and On-going.</p> <p>1.All transfusion records will continue to be audited by lab personnel for adherence to policy and completeness. In the current process any incomplete record is returned to the transfusionist for completion. Beginning October 5, 2015 any records that have times that are inconsistent with the policy such as the same time for pre-transfusion V/S and start time shall be reported through Risk Monitor Pro and an action plan or follow up will be required by the department manager.</p> <p>Responsible Person(s): Blood Bank MT Coordinator and Each Nursing Manager will follow-up on Risk Monitor Pro. Deficiency to be corrected as of October 5, 2015 and be On-Going</p> <p>1.An educational communication will be sent out to blood bank staff currently auditing records to assure identification of these concerns moving forward. (See Attachment S 952 C)</p> <p>Responsible Person(s): Director of Patient Care Services Deficiency corrected 9-29-15.</p>	

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S 1162  Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on document review, observation and staff interview, the facility failed to comply with manufacturer recommendations for the Hydrocollator located in the Occupational Therapy Department and failed to record the temperatures of the Hydrocollator daily per hospital policy.</p> <p>Findings included:</p> <p>1. The Operation Manual instructions for the use and operation for Rehabilitation Department's Hydrocollator E-1 Master Heating Units notes the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature is 160 to 166</p>	S 1162	<p>S 1162 1-4</p> <p>1. The Rehabilitation Department recognizes that the recommended operating temperature is 160-165 degrees Fahrenheit. Review of the Chattanooga manual for hydrocollators indicates this. The water logs revealed the water temperature was 150 degrees Fahrenheit on 3 days in July and 5 days in August, 2015.</p> <p>2. The hydrocollator policy for Rehab Services has been updated to indicate 160-165 degrees Fahrenheit is the temperature that is appropriate to be used with these units housed in the department.</p> <p>3. The water temperature is</p>	09/02/2015			

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	<p>degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs.</p> <p>2. The Franciscan St Francis Health-Mooresville Moist Heat (Hydrocollator Packs) policy (last reviewed May 2015) indicated the Hydrocollator temperature will be maintained between 165 to 175 degrees Fahrenheit and will be recorded on log sheet daily.</p> <p>3. At 3:15 PM on 9/1/2015, the Occupational Therapy Department was toured. The department had a table top Master Heating Chattanooga E-1 unit. The July and August Hydrocollator Temperature Log evidenced the water temperature was recorded at 150 degrees Fahrenheit on each day. The temperatures were recorded on 3 days in July and 5 days in August.</p> <p>4. At 11:45 AM on 9/2/2015, staff member #19 (Occupational Therapy Manager) confirmed the hospital policy did not comply with the manufacturer's recommended use directions. The staff member confirmed the Hydrocollator temperatures were not recorded daily as defined in hospital policy.</p>		<p>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 of 160-165 F.</p> <p>4. The Franciscan St. Francis Health Moist Heat (Hydrocollator Packs) policy has been updated (September, 2015) to indicate the Hydrocollator temperature will be maintained between 160-165 degrees Fahrenheit unless indicated otherwise on individual units and will be recorded on a log sheet daily. (See Attachment Logs S1162 A) The Rehab Tech has been given instructions to contact Biomed should the temperature be outside the range listed. The manager of Therapy Services in Mooresville will be responsible for oversight of the Rehab tech and the temperature log. This process was modified from previous activity on 9-2-14.</p> <p>Responsible Person(s): Manager of Therapy Services</p> <p>Deficiency Corrected: 9-2-15</p>	

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S 1164 Bldg. 00	<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, observation and staff interview, the facility failed to assure preventive maintenance (PM) was conducted on Environmental Service's automatic floor scrubbers and the In-patient Rehabilitation wooden steps</p> <p>Findings included:</p> <p>1. Franciscan St. Francis Health-Mooresville Preventive Maintenance Policy (last reviewed 4/20/2015) indicated preventive maintenance shall be performed on all patient care and non-patient care equipment. Records of all preventive maintenance should be maintained and</p>	S 1164	<p>S 1164</p> <p>1. The rehabilitation department recognizes the Rule that there shall be evidence of preventative maintenance on all equipment specifically for wooden steps. 2. Evidence was obtained for preventative maintenance on the wooden steps located in the Inpatient Physical Therapy gym at Mooresville Franciscan St. Francis Health. The wooded stairs were last serviced and inspected on 1/28/15. The sticker indicating inspection was located on the back of the stairs and difficult to locate without moving the steps. 3. The inspection sticker has been moved to the side of the stairs for easy viewing. This was</p>	10/09/2015

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	<p>up to date on an annual basis.</p> <p>2. Review of facility documents on preventive maintenance of patient care equipment and environmental service (EVS) equipment indicated the hospital lacked evidence of preventive maintenance having been conducted on the In-patient Rehabilitation wooden steps and EVS floor scrubbers.</p> <p>3. At 11:00 AM on 9/2/2015, the In-patient Rehabilitation Therapy Department was toured. The wooden therapy steps were observed without an asset tag or preventive maintenance sticker.</p> <p>4. At 11:10 AM on 9/2/2015, staff member #24 (Registered Nurse) confirmed the piece of patient care equipment located in the In-patient Rehabilitation Therapy Department did not have an asset tag or a PM sticker on it.</p> <p>5. At 1:15 PM on 8/31/2015, staff member #4 (Engineering Director) indicated the floor scrubbers are being inspected when the manufacturer needs to be called because the scrubber quit operating. The staff member indicated his/her department does not have a routine preventive maintenance schedule</p>		<p>completed on 9-2-2015. (Please see attached S1164 A - Work Order Service Information record Control #216563 and S1164 B – Inspection Sticker in visible area.)</p> <p>4. A discussion took place with Biomed to ensure that following inspection and any preventative maintenance necessary, that stickers would be placed in areas that are prominent for viewing. This will allow easier access for review by staff and for future inspections. Responsible Person: Biomed Engineering Deficiency Corrected on 9-2-15</p> <p>Maintenance of patient care equipment and environmental service (EVS) equipment lacking evidence of preventive maintenance having been done on the In-Patient Rehabilitation wooden steps and EVS floor scrubbers.</p> <p><b>Plan of Correction:</b></p> <p>-</p> <p>1.This deficiency is in the process of being corrected. A PM on the Mooresville EVS floor scrubbers will be conducted before October 9, 2015. The PM will match the format of the attached PM for EVS floor scrubbers. (See attachment S1164 C.)</p> <p>2.Deficiency reoccurrence will be prevented by implementing a quarterly PM on the Mooresville EVS floor scrubbers.</p>				

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S 1186 Bldg. 00	<p>for the hospital's automatic floor scrubbers.</p> <p>6. At 11:45 AM on 9/2/2015, staff member #19 (Physical Therapy Director) indicated the Clinical Engineering Department did not have documented evidence of the therapy steps having had PM conducted on them and the steps were not on the clinical asset equipment report.</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.</p>		<p>Responsible Person(s): Director of Environmental Services</p> <p>Deficiency Corrected by 10-9-15</p>	

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	<p>(E) A written fire control plan that contains provisions for the following:</p> <ul style="list-style-type: none"> <li>(i) Prompt reporting of fires.</li> <li>(ii) Extinguishing of fires.</li> <li>(ii) Protection of patients, personnel, and guests.</li> <li>(iv) Evacuation.</li> <li>(v) Cooperation with firefighting authorities.</li> </ul> <p>Based on documentation review and staff interview, the facility failed to provide documented fire drills for Franciscan St Francis Health - Franklin Infusion and Franciscan St Francis Health Center Pain-Mooresville off sites.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Franciscan St. Francis Health-Mooresville 2015 Management Plan for Life Safety and Fire Control indicated that staff is adequately trained on the fire plans through mandatory training, orientation and participation in fire drills. All hospital department are mandated to participate in fire drills. Fire Drills shall be held as required by HFAP (Healthcare Facilities Accreditation Program) standards.</li> <li>2. HFAP physical environment standard 11.04.02 Fire Drills - quarterly stated, "Fire drills shall be conducted at least quarterly on all shifts in all buildings where patients are treated and/or housed. Annually (per shift) in non-patient care</li> </ol>	S 1186	<p>S1186</p> <p><b>Plan of Correction:</b></p> <ol style="list-style-type: none"> <li>1. The Franklin Infusion Center and the Pain Clinic have been added to the listing of FSFH Mooresville off-sites for fire drills for quarterly drills. (See Attachment S1186 A – Fire Drill performed at Franklin Infusion on 9-25-15, and Attachment S1186 B – Fire Drill performed at Mooresville Pain Clinic on 8-11-15.) Fire drills are conducted by individual practices and documentation of said drills is provided to the Safety Department at FSFH Indianapolis campus.</li> </ol> <p>Responsible Person(s): Director of Security, Safety, and Telecommunications Correction Date: 7-1-15</p> <ol style="list-style-type: none"> <li>2. Fire drills for all off-sites under hospital licenses are monitored by the Safety Department. As the Infusion Center and Pain Clinic have been added to FSFH Mooresville's license (effective June 2015), they have been rolled into the existing tracking process.</li> </ol>	09/25/2015

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S 2104 Bldg. 00	<p>buildings."</p> <p>3. A memorandum dated September 1, 2015 indicated there was no documented evidence of fire drills conducted for Franciscan St Francis Health - Franklin Infusion and Franciscan St Francis Health Center Pain - Mooresville off sites.</p> <p>4. At 10:30 AM on 9/2/2015, staff member #4 (Engineering Director) confirmed there was no documented evidence that the pain clinic and the infusion center conducted fire drills.</p> <p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8(a)</p> <p>(a) If the hospital provides inpatient or ambulatory surgical services, the services shall meet the needs of the patients served, within the scope of the service offered, and in accordance with acceptable standards of practice and and safety. Based on document review, observation and staff interview, the facility failed to ensure the six operating rooms met the required temperature as defined by hospital policy and American Society of Heating, Refrigeration, and Air</p>	S 2104	<p>Responsible Person(s): Director of Security, Safety, and Telecommunications Correction Date: 8-11-15 for Pain Clinic and 9-25-15 for Franklin Infusion Center</p> <p>S 2104</p> <p>1. Franciscan St. Francis policy "Infection Control for Engineering" approved at Infection Control Committee 9/17/2015 states under section 2.f. (See Attached S2104 A</p>	11/18/2015

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	<p>Conditioning Engineers (ASHRAE) guidelines.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Franciscan St. Francis Health-Mooresville Infection Control Policy for Engineering (last reviewed 2/2/2015) indicated the daily monitoring of the operating room temperature to be maintained between 68 and 73 degrees Fahrenheit and the relative humidity to be maintained from 20% to 60%.</li> <li>AORN (Association of periOperative Registered Nurses) 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 range should be between 68 F and 73 F, while, the humidity should be between 30% and 60%.</li> <li>Staff member #4 (Director of Engineering) provided documented evidence for 6 operating rooms' temperature and relative humidity dated from June 4, 2015 to August 30, 2015. The documentation evidenced a consistency that the operating rooms were registering below 67 degrees</li> </ol>		<p>and minutes approving policy S2104 B). "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 variations in the operating room to be outside of these recommended ranges."</p> <p>Engineering personnel shall monitor the OR temperature and humidity for compliance to these ranges on a daily basis. Engineering shall notify peri-operative service manager or designee immediately of critical value of humidity greater than 70% and appropriate adjustments are to be made in temperature to decrease humidity back below this level. Franciscan St. Francis Health recognizes that there are various and unique circumstances that require adjustment of temperature (which will impact humidity) outside of this 68-73 degrees Fahrenheit. In these instances, the risk and benefits are considered to determine if an appropriate exception should be made. One such circumstance is the excessive warming of the surgical staff during an orthopedic procedure where many layers of protective equipment are utilized including hoods. In addition, these cases are performed under the added heat of surgical and ultraviolet lights. In this case, the risk of field contamination by</p>	

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	<p>Fahrenheit and the relative humidity level exceeded 60% over half of the recorded period. The average temperatures of the 6 operating rooms were approximately 62 degrees Fahrenheit.</p> <p>4. On 8/31/2015 at 1:00 PM, staff member #1 (Director of Clinical Services) indicated the hospital shall ensure the operating room temperatures meet the requirements defined by AORN.</p> <p>5. On 8/31/2015 at 2:15 PM, staff member #4 (Director of Engineering) indicated the Engineering Department controls the range setting of the operating rooms. The range the staff may adjust the temperature for operating rooms was between 60 to 75 degrees Fahrenheit. The staff member confirmed the engineering control range was not in compliance with hospital policy or AORN guidelines.</p> <p>6. At 10:25 AM on 9/1/2015, operating room #1 was toured with staff member #15 (Surgery Manager). The thermostat was set at 55 degrees Fahrenheit and the operating room was very cool.</p> <p>7. At 10:30 AM on 9/1/2015, staff member #15 (Surgery Manager) indicated the physician likes the room cold.</p>		<p>"sweat" and the potential impact on performance of any member of the surgical team that is overheated takes precedence over the risk of bacterial /fungal growth in the OR during the duration of surgical procedure.</p> <p>Therefore, Franciscan St. Francis accepts this circumstance as unique and the operating room may adjust the temperature accordingly. At the conclusion of the unique circumstance, the OR staff will adjust the temperature to 68 degree Fahrenheit.</p> <p>Recognizing that "unique" circumstances do exist, Franciscan St. Francis will mitigate the risk of bacterial or fungal growth by:</p> <ol style="list-style-type: none"> <li>a. Utilizing Ultraviolet lighting in the duct work to reduce contamination in the air entering the room</li> <li>b. Ultraviolet lighting is available over the surgical field</li> <li>c. Air quality is monitored in all operating rooms biannually for bacteria and fungal growth</li> <li>d. The current policy/or process and a discussion regarding "unique" circumstances shall occur at the Surgical Section Meeting, 11/18/15.</li> <li>e. Educating the OR staff to this process, by the Clinical Services Director, by October 31, 2015.</li> </ol> <p>2. The Director of Engineering ensures daily monitoring of OR temperature and humidity, provides reports of that monitoring when requested, continues maintenance of equipment to mitigate the risk of</p>	

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			<p>bacterial or fungal growth specific to ultraviolet lighting in the duct work, surgical field; monitors air quality in the ORs biannually for the presence of bacterial or fungal growth. The OR Manager will review the Surgical Site Infection report monthly. (See Attachment S2104 C)</p> <p>3. This plan of correction is the dual responsibility of the Director of Engineering and the OR Manager.</p> <p>4. Risk Mitigation processes are in place and on-going as of 9/30/15. The current process/policy will be discussed at the Surgical Section Meeting 11/18/15.</p> <p>Responsible Person(s): Director of Engineering OR Manager</p> <p>Date of Correction: 11/18/15</p>		