# Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00
B. WING

**Date Survey Completed:** 11/01/2012

**Name of Provider or Supplier:** ST VINCENT FRANKFORT HOSPITAL INC

**Street Address, City, State, Zip Code:** 1300 S JACKSON ST FRANKFORT, IN 46041

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**Summary Statement of Deficiencies**

This visit was for a State hospital licensure survey.

**Dates:** 10/31/2012 through 11/1/2012

**Facility Number:** 005039

**Surveyors:**

- Albert Daeger, CFM, SFPIO
- Medical Surveyor
- Saundra Nolfi, RN
- PH Nurse Surveyor

**QA:** clauthlin 11/16/12

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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.
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### IDENTIFICATION NUMBER:

151316

### STATEMENT OF DEFICIENCIES

**PREFIX**

**TAG**

**ID**

**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

**PROVIDER'S PLAN OF CORRECTION**

(Each corrective action should be cross-referenced to the appropriate deficiency)

### CROSS-REFERENCED TO THE APPROPRIATE

**FRANKFORT, IN 46041**

151316

### ST VINCENT FRANKFORT HOSPITAL INC

1300 S JACKSON ST

FRANKFORT, IN 46041

**S0406**

410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT

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, the facility failed to ensure 2 services (Laundry/Linen and Housekeeping) provided by contractors were included in its comprehensive quality assessment and improvement (QA&I) program.

Findings included:

1. St. Vincent Frankfort Hospital Performance Improvement and Patient Safety Plan implements each clinical, non-clinical, and medical staff department/service is involved in the improvement of organizational performance. Each

1.) Laundry/linen service department added to PCRC scorecards. Housekeeping was previously measured as part of the Dietary/Housekeeping scorecard so that will be separated out as its own scorecard. Measures will be audited and assessed monthly and reported to Performance Improvement committee on a quarterly basis. 2.) To maintain compliance with state measure, laundry/linen quality scorecard will be added to PCRC standing agenda items for each quarterly PCRC meeting. 3.) Environmental service manager to be responsible for auditing and completing launcry/linen quality scorecard. 4.) An annual site visit will be scheduled to evaluate the quality standards at vendor's site. Manager and Infection Preventionist will attend. 5.)
department is responsible for monitoring the performance of services provided within its structure.

2. The 2011 and 2012 Performance Improvement and Patient Safety Committee minutes were reviewed. The minutes and the data did not evidence the contracted services of Laundry/Linen and Housekeeping were being evaluated.

3. At 3:40 PM on 11/1/2012, staff member #1 confirmed the two contracted services were not being evaluated by the hospital's Performance Improvement and Patient Safety Committee.

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<td>Housekeeping staff will conduct weekly linen checks of 5 bundles of linens per week to ensure linen is free of stains, holes, and generalized dirt. Failures will be reported to the housekeeping manager and through the PCRC committee. Linen shortages will be reported as well.</td>
<td>11/30/12</td>
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</table>
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**IDENTIFICATION NUMBER:** 151316

**DATE SURVEY COMPLETED:** 11/01/2012

**NAME OF PROVIDER OR SUPPLIER:** ST VINCENT FRANKFORT HOSPITAL INC

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1300 S JACKSON ST

**FRANKFORT, IN 46041**

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<tr>
<td>S0554</td>
<td>410 IAC 15-1.5-2</td>
<td>INFECTION CONTROL</td>
<td>(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 policy review, observation, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage. Findings included: 1. The facility policy &quot;Crash Cart Integrity for Adult, Neonatal and Pediatric&quot;, last revised 12/2010, indicated, &quot;...5. The contents and expiration dates of all items in the crash bag shall be checked, at a minimum, monthly, and after each use of the bag. This check should be recorded on the Crash Bag Inventory Log. The responsibility for this monthly check will be assigned by the Unit Supervisor and rotated throughout the staff nurses.&quot; 2. During the tour of the 2 South Med/Surg Unit at 11:20 AM on 10/31/12, accompanied by staff members #A1, the following items were observed in the crash cart: A. One of three lavender top lab tubes expired 09/2012. B. Two of two Pedi-cap CO2 detectors, one expired 08/2012 and one expired 09/2012. C. One of one 500 milliliter bag of sterile water expired 1 Aug. 2012. 3. While still on the 2 South Med/Surg Unit at 12:05 PM on 10/31/12, accompanied by staff members #A and A2, the following items were</td>
<td>1.) All expired IV fluids, medications, and lab tubes removed from service day of survey and discovery from all refrigerators, medication rooms, supply carts, and pediatric and adult crash carts. 2.) Crash cart integrity checks to be completed monthly and after use of each bag/cart in all departments. Outdates of supplies, meds, and lab tubes to be assessed monthly. Items expired are to be removed from cart/bag immediately upon discovery. 3.) Department managers to add crash cart outdates to PCRC quality scorecard and report quarterly. Quality improvement department to audit compliance with crash cart integrity checks monthly for 6 months. Quality Manager will determine after the initial 6 months if an additional 6 months of monitoring is required based on compliance. 4.) Deficiency to be corrected</td>
<td>11/30/2012</td>
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<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>observed in the Pediatric Emergency Black Bag:</td>
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<td>A. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the yellow sleeve.</td>
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<td></td>
<td>B. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the green sleeve.</td>
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<td></td>
<td>C. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the orange sleeve.</td>
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<td></td>
<td>D. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the white sleeve.</td>
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<td></td>
<td>E. One of one green top lab tube and one of one lavender top lab tube, both expired 09/2012, in the blue sleeve.</td>
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<td>F. One of one Pediatric Ambu-laryngeal mask expired 07/2011.</td>
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<td></td>
<td>4. At 12:15 on 10/31/12, accompanied by staff members #A1 and A2, the following items were observed in the cabinet in the old medication room of the nurses' station of the 2 South Med/Surg Unit:</td>
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<td></td>
<td>A. Eight of eight BBL Culture Swab tubes with medium, four expired 03/2009, one expired 09/2010, two expired 02/2011, and one expired 04/2011.</td>
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<td></td>
<td>5. At 12:15 PM on 10/31/12, staff member #A2 indicated there was no record of monthly checks of the emergency supplies.</td>
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<td>6. During the tour of the Obstetrical Department at 12:30 PM on 10/31/12, accompanied by staff members #A1 and A10, the following items were observed in the 2 supply carts in the nursery:</td>
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<td></td>
<td>A. One of four Povidone Iodine swabs expired 04/2010.</td>
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</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 151316

**DATE SURVEY COMPLETED:** 11/01/2012

**NAME OF PROVIDER OR SUPPLIER:** ST VINCENT FRANKFORT HOSPITAL INC

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1300 S JACKSON ST, FRANKFORT, IN 46041

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<td>TAG</td>
<td>B. One of one 20 milliliter vial of 0.9% sodium chloride expired 1 June 2012.</td>
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<td></td>
<td>C. Three of three 20 milliliter vial of 0.9% sodium chloride expired 1 August 2012.</td>
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<td>D. Two of two green cap mini lab tubes with medium expired 10/2011.</td>
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<td></td>
<td>E. Two of two lavender cap mini lab tubes with medium expired 04/2012.</td>
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<td></td>
<td>F. Two of two red cap mini lab tubes with medium expired 10/2011.</td>
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<td></td>
<td>G. Two of two blue cap mini lab tubes with medium expired 09/2011.</td>
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<td></td>
<td>7. During the tour of the Surgery Department at 1:50 PM on 10/31/12, accompanied by staff members #A1 and A11, nine of nine 50 milliliter vials of sterile water with an expiration date of 1 Oct. 2012 were observed in the OR storage room refrigerator. Staff member #A11 indicated he/she didn't know how they were missed because he/she and the staff were very conscientious about outdates.</td>
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<td>S0610</td>
<td>410 IAC 15-1.5-2</td>
<td>INFECTION CONTROL</td>
<td>410 IAC 15-1.5-2(f)(3)(D)(x)</td>
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1.) Pedialyte and Similac found stored under lights in material handling department were removed the date of survey from service.
2.) All light sensitive nutrients will be stored in closed containers in the material handling department until they are used or are placed in closed cabinets for the different areas of service.
3.) Materials will add monitoring of this product to their...
Findings included:

1. At 1:05 PM on 10/31/2012, the Material Handling Department was toured. A storage rack containing 52 Similac Advance and 64 Pedialyte were observed removed from their cases and were placed on the shelves of the storage rack. Above the storage racks and other locations throughout the dry storage room were 4-bulb ceiling mounted fluorescent light fixtures.

2. The manufacturer's label of Similac and Pedialyte high-protein nutrition states, "Contains light-sensitive nutrients."

3. At 1:15 PM on 10/31/2012, staff member #1 confirmed the label of the tube feeding nutrients were light sensitive and the tube feeding supplements were stored on a shelf exposed to bright lights in the Material Handling Department.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**IDENTIFICATION NUMBER:** 151316  
**MULTIPLE CONSTRUCTION**  
**BUILDING:** 00  
**WING:**  
**DATE SURVEY COMPLETED:** 11/01/2012

### NAME OF PROVIDER OR SUPPLIER

**ST VINCENT FRANKFORT HOSPITAL INC**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**  
1300 S JACKSON ST  
FRANKFORT, IN 46041

### SUMMARY STATEMENT OF DEFICIENCIES

**PREFIX**  
**TAG**

#### (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tr>
<td>S0744</td>
<td>410 IAC 15-1.5-4</td>
<td>MEDICAL RECORD SERVICES</td>
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<td>S0744</td>
<td>410 IAC 15-1.5-4 (e)(1)</td>
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#### (e) All entries in the medical record shall be:

1. **1) legible and complete;**

   Based on medical record review and interview, the facility failed to ensure all forms were accurate and completely filled out for 10 of 14 closed patient records reviewed (#N1, N3, N5, N6, N7, N8, N9, N10, N12, and N14).

#### Findings included:

1. **The Emergency Physician Record from 04/01/12 for patient #N1 lacked documentation by the physician of a "Condition on Disposition" from the ER.**

2. **The Discharge Teaching Summary from 05/24/12 for patient #N3 lacked documentation of follow-up care in the spaces provided.**

3. **The Emergency Physician Record from 04/16/12 for patient #N5 indicated the disposition from the ER was to home when the patient was actually admitted to the hospital.**

4. **The Emergency Physician Record from 08/02/12 for patient #N6 lacked documentation by the physician of a time for the disposition from the ER. Also, the "Consent: Information- Records- Treatment- Financial Responsibility" was totally blank.**

5. **The Emergency Physician Record from 07/13/12 for patient #N7 lacked documentation by the physician of a time for the disposition from the ER.**

#### PROVIDER'S PLAN OF CORRECTION

**PREFIX**  
**TAG**

#### (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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1. **1) ER manager to reeducate physicians of components of complete medical record.**

   Condition on disposition and time of disposition to be completed on all ER patients. Correct disposition to be documented by ER physician. Email instructions sent to those physicians who are not currently on the schedule. A) Condition on disposition and time of discharge added to the emergency room performance improvement scorecard. (See attached scorecard) 30 charts will be audited and reported to ERPI committee monthly for a minimum of 12 months. B) Quality improvement department to monitor standard compliance and report to ER manager and ER medical director on monthly basis. Quality Manager will determine the need for further evaluation at the end of the 12 month period based on increased/decreased compliance.

#### ADDENDUM:

The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for
6. The Emergency Physician Record from 02/29/12 for patient #N8 lacked documentation by the physician of a time for the disposition from the ER.

7. The Emergency Physician Record from 02/18/12 for patient #N9 lacked documentation by the physician of a "Condition on Disposition" from the ER, a time, and that the patient was admitted. Also, the "Multidisciplinary Care Team Patient Needs/Problems and Teaching" form lacked documentation of dates identified and dates resolved for any problems identified.

8. The Emergency Physician Record from 07/13/12 for patient #N10 lacked documentation by the physician of a time for the disposition from the ER.

9. The Emergency Physician Record from 07/13/12 for patient #N12 lacked documentation by the physician of a time for the disposition from the ER.

10. The "Consent: Information- Records- Treatment- Financial Responsibility" was totally blank for patient #N14, an infant born 03/30/12.

11. At 3:00 PM on 11/01/12, staff members #A2 and A19, who navigated the Electronic Medical Records (EMR), confirmed the medical record findings. Also, staff member #A1 indicated the infant should have a consent form signed.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151316

NAME OF PROVIDER OR SUPPLIER
ST VINCENT FRANKFORT HOSPITAL INC

STREET ADDRESS, CITY, STATE, ZIP CODE
1300 S JACKSON ST
FRANKFORT, IN 46041

SUMMARY STATEMENT OF DEFICIENCIES

PREFIX TAG ID
410 IAC 15-1.5-8 S1118

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 policy and procedure review, observation, and interview, the facility failed to ensure a safe environment for patients by following their policy regarding warmed fluids in the Obstetrical and Surgery Departments.

Findings included:

1. The facility policy "Warmed IV Fluids and Irrigation Solutions Storage", approved December 15, 2011, indicated, "...A. IV fluids within their plastic overwrap and bottles of irrigation solution may be placed in a fluid warmer to be warmed to a maximum temperature of 104 degrees Fahrenheit (40 degrees Celsius). 1. Fluids may be stored in the warmer for a maximum of 14 days. ...5. The IV bag or bottle or irrigation fluid must be labeled with the following information: a. Date placed in warmer. b. Date bag should be removed from warmer. c. Expiration date."

2. During the tour of the Obstetrical Department at 12:45 PM on 10/31/12, accompanied by staff members #A1 and A10, a warming unit was observed in the nurses' station. The bottom portion of the unit contained three 1500 milliliter fluids.

The policy titled "Warmed IV Fluids and Irrigation Solutions Storage" has been changed to include information regarding the Temperature Recorders and Logs for the Warmers. Warmer logs have been established for all warmers with a range requirement of 104 degrees or below. In departments that are staffed 24/7, all warmers are to be checked daily and the temperatures logged. Any report of temperature 105 degrees or greater will be addressed with Plant Maintenance and all fluids will be removed until temperature falls within required range. Once removed, fluid will be redated as per policy guidelines. Those departments that are not staffed 24/7 will check the Temperature Recorder upon reopening to ensure that the Temperature has not exceeded 104 degrees. If at any time the Temperature did exceed 104 degrees, all fluids will be removed and temperatures will be checked daily.
3. During the tour of the Surgical Department at 1:05 PM on 10/31/12, accompanied by staff members #A1 and A11, an Amsco warmer was observed in the OR hallway. The top portion contained blankets and a bottle of lotion and the bottom portion contained IV and irrigation fluids. Staff member #A11 indicated the fluids were dated when they were placed in the warmer and staff knew they had a 14 day use. He/she indicated the warmer was monitored Monday through Friday and the temperature range was 105-110 degrees F, with the standard being 108 degrees F. He/she indicated the temperature standard was provided by the fluid manufacturer, but did not have any documentation of this. The October 2012 temperature log indicated 3 days registered 106 degrees F., 8 days registered 107 degrees F., 6 days registered 108 degrees F., and 5 days registered 109 degrees F.

4. At 11:00 AM on 11/01/12, staff member #A1 indicated he/she could not provide temperature range documentation from the fluid manufacturer and confirmed the units were not following the facility policy regarding dating and monitoring the fluids in the warmers.
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<tr>
<td>S1164</td>
<td>410 IAC 15-1.5-8</td>
<td>1.) Temperature log on hydrocollator to be completed daily Monday-Friday by physical therapy staff. Director delegated responsibility to staff member who is in the department on regular M-F basis. Any out of ranges temps are to be reported to the director of PT. (2) PT manager to review log for completion and report monthly on PCRC scorecard and reported quarterly to committee. Quality improvement to audit completion rate of hydrocollator log monthly for 12 months to insure compliance with standard. Quality Manager will determine after the initial 12 months if an additional 6 months of monitoring is required based on compliance.</td>
<td>11/30/2012</td>
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Based on document review and staff interview, the facility failed to daily record the hydrocollator temperatures as per hospital policy.

Findings included:

1. St. Vincent Frankfort Hospital's Physical Therapy Department Safety policy; last reviewed March 2011, specifies the department's hydrocollator to record daily hot pack temperature checks.

2. The Hydrocollator Temperature Logs were reviewed between for the first 10 months of 2012 and the temperature logs revealed 21% of the daily temperature checks were...
### Summary of Deficiencies

1. **Deficiency 1:** On November 1, 2012, staff member #12 indicated he/she was only at the hospital once a week and was the only one responsible to record the hydrocollator daily temperatures. The staff member confirmed the data provided was accurate, and the data revealed the temperatures of the hydrocollator were not being recorded as required by policy.

2. **Deficiency 2:** This Plan of Correction completed: January 5 of 31 days; February 1 of 29 days; March 7 of 31 days; April 9 of 30 days; May 10 of 31 days; June 9 of 30 days; July 11 of 31 days; August 11 of 31 days; September 2 of 30 days; and September 9 of 31 days.

3. **Deficiency 3:** At 3:45 PM on 11/1/2012, staff member #12 indicated he/she was only at the hospital once a week and was the only one responsible to record the hydrocollator daily temperatures. The staff member confirmed the data provided was accurate, and the data revealed the temperatures of the hydrocollator were not being recorded as required by policy.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151316

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

ST VINCENT FRANKFORT HOSPITAL INC

STREET ADDRESS, CITY, STATE, ZIP CODE

1300 S JACKSON ST
FRANKFORT, IN 46041

SUMMARY STATEMENT OF DEFICIENCIES

PREFIX TAG ID
S1168 410 IAC 15-1.5-8 PHYSICAL PLANT
410 IAC 150-1.5-8 (d)(3)

PREFIX TAG ID
S1168 All nursing departments that are
staffed 24/7 will conduct
defibrillator checks every 12
hours per manufacturer’s
recommendations. Within the
Surgery department the
defibrillator in the PACU will be
checked daily M-F between 7am
-3pm as the PACU is not opened
for emergent cases. The
defibrillator in the OR however,
can be used for emergent
after-hours cases, therefore the
House Supervisors will check it
for the night shift M-F and for
both day and night shift on
Sat-Sun. Quality Manager will
audit the defibrillator logs for 6
months and determine at that
time if additional monitoring is
needed based on compliance
<100%. All Department Managers
should have defibrillator log
placed on PCRC scorecard.

ADDENDUM: The
Chief Nursing Officer will be the
responsible person to ensure
implementation, continued
monitoring, and compliance for
this Plan of Correction.

PREFIX TAG
S1168 11/30/2012

Findings included:

1. During the tour of the 2 South Med/Surg Unit
at 11:20 AM on 10/31/12, accompanied by staff
member #A2, A Zoll M defibrillator was observed
on the crash cart with a log of daily checks for
October 2012. Staff member #A2 indicated the
defibrillator is checked and discharged daily,
usually on the night shift.

2. During the tour of the Obstetrical Department
at 12:20 PM on 10/31/12, accompanied by staff
members #A1 and A10, A Zoll M defibrillator was
observed on the crash cart with a log of daily
checks for October 2012. Staff member #A10
indicated the defibrillator is checked and
discharged daily.

3. During the tour of the Surgical Department at
1:15 PM on 10/31/12, accompanied by staff
members #A1 and A11, A Zoll M defibrillator was
observed on the crash cart with a log of Monday
through Friday checks for October 2012. Staff

(d) The equipment requirements are as follows:

(3) Defibrillators shall be discharged
at least in accordance with
manufacturers recommendations and a
discharge log with initialed entries
shall be maintained.

Based on document review, interview,
manufacturer's directions, and policy
and procedure review, the facility failed to ensure the
defibrillator checks were performed according to
policy and manufacturer's instructions.

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S1168 11/30/2012
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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**Summary Statement of Deficiencies**

Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information

Member #A11 indicated the defibrillator is checked and discharged daily when the surgery department is open. He/she confirmed that emergency surgery or cesarean sections might be performed during the night or on weekends.

### 4. During the tour of the Emergency Department at 9:25 AM on 11/01/12, accompanied by staff members #A1 and A20, a Zoll M defibrillator was observed on the crash cart with a log of daily checks for October 2012. Staff member #A20 indicated all of the defibrillators are checked and discharged daily.

### 5. The manufacturer's directions for the Zoll M Series defibrillator indicated, "...Resuscitation equipment must be maintained to be ready for immediate use. The following operational checks should be performed at the beginning of every shift to ensure proper equipment operation and patient safety." The instructions continued with a list of all the checks to be performed including checking all of the supplies and discharging the unit.

### 6. The facility policy "Crash Cart Integrity for Adult, Neonatal and Pediatric", approved 12/2010, indicated, "...3. c. Check your defibrillator at the manufacturer's suggested joules each shift (on Crash Carts)."

### 7. At 2:15 PM on 10/31/12, staff member #A1 confirmed the defibrillators were not being checked each shift and that emergency surgeries or cesarean sections might be performed during nonroutine OR times.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151316

FACILITY NAME: ST VINCENT FRANKFORT HOSPITAL INC
ADDRESS: 1300 S JACKSON ST
FRANKFORT, IN 46041

DATE SURVEY COMPLETED: 11/01/2012

DEFICIENCY

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SUMMARY STATEMENT OF DEFICIENCIES
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TAG
COMPLETION DATE

S1172
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 current principles of the following:

(A) Asepsis
(B) Cross-infection; and
(C) Safe practice.

Based on interview, product information, and training records, the facility failed to provide environmental services to ensure safe infection control practices throughout the facility.

Findings included:

1. At 9:20 AM on 11/01/12, environmental staff member #A21 was interviewed in the emergency department. He/she indicated Alpha-HP multi-surface cleaner was used in a bucket of solution to wipe all surfaces and patient carts in the emergency department, then he/she waited for 3 to 5 minutes before remaking the carts. He/she indicated this same cleaner was used in the buckets to mop the floors. He/she indicated Crew M was used in the bathrooms and either Dispatch or Expose 256 was used for any blood or body fluid areas. He/she indicated the wait time for the Expose 256 was 5 minutes, but the manufacturer's

Alpha HP multi-surface cleaner was replaced with Alpha HP Disinfectant which is now used hospital-wide for routine cleaning. Inservices were conducted for all housekeeping staff describing the specifications from the manufacturer and that the Alpha HP Disinfectant should be used for all routine cleaning throughout the hospital. Also educated on use of Expose II 256 Phenolic Disinfectant Cleanser for MRSA and Dispatch Wipes for areas exposed to C-difficile. MSDS sheets were also reviewed with staff to explain how to know what a product is made of and how to determine its effectiveness on organisms. There was an inservice on 11/09/2012.
ST VINCENT FRANKFORT HOSPITAL INC

SUMMARY STATEMENT OF DEFICIENCIES

1. At 10:00 AM on 11/01/12, the Infection Preventionist, staff member #A13, indicated the environmental services were provided by a contracted service who supplied their own chemicals. He/she indicated he/she provided generic training regarding C-diff and terminal cleaning, but not specific to any chemicals. He/she indicated MSDS (Material Safety Data Sheets) for the various chemicals were provided by the company, but they did not address organism effectiveness or instructions for use.

2. At 10:30 AM on 11/01/12, the supervisor of the contracted service, staff member #A5, provided product information for the various chemicals used. The literature for Alpha-HP multi-surface cleaner indicated, "An all-in-one, multi-purpose cleaner concentrate based on proprietary Accelerated Hydrogen Peroxide (AHP) technology. ...Blends commonly used chemicals with low levels of hydrogen peroxide for high productive cleaning. Use on all washable surfaces. Multiple dilution rates. Use as a carpet prespray or carpet extraction cleaner." The literature lacked any information regarding effectiveness against organisms or any disinfectant properties. Staff member #A5 indicated the new company took over in March 2012 and all employees were educated regarding new chemicals. He/she indicated two employees had allergic reactions to one of the chemicals and he/she called the company and was told the Alpha-HP cleaner could take the place of the one they were using. He/she agreed the product was a cleaner and not a disinfectant.

3. At 4:30 PM on 11/01/12 during the exit

Infection Preventionist will conduct monthly rounding on all housekeeping carts and interview a minimum of 2 housekeepers to ensure use of an approved Disinfectant for hospital surfaces. Preventionist will also, in conjunction with the Housekeeping Manager, conduct semi-annual education with the housekeeping staff in regard to specifications of products and what organisms are susceptible to each product.

ADDENDUM: The Chief Nursing Officer will be the responsible person to ensure implementation, continued monitoring, and compliance for this Plan of Correction.
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<td>conference, staff member #A5 indicated he/she called the company regarding this issue and was told there was a similarly named product that was a disinfectant and apparently there was some miscommunication.</td>
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<td>CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
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<td>4. Review of the employee file for environmental staff member #A21 indicated a training packet with the staff member's name written on the top, but without any date or signatures of any actual training.</td>
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<td>5. The employee files for environmental staff members #A22 and A23 lacked any documentation of training or orientation.</td>
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