

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S000000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 005050</p> <p>Date of Survey: 01/14-16/13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Stephen Poore Medical Surveyor</p> <p>QA: claughlin 01/24/13</p>			S000000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on policy and procedure review, employee personnel file review, and staff interview, the hospital failed to ensure that human resources implemented its policy related to background checks for 5 of 6 nurse aide files reviewed. (staff P3, P4, P5, P12 and P13)</p> <p>Findings:</p> <p>1. at 10:30 AM on 1/15/13, review of the policy and procedure "Employment Process", policy number 106897, with an effective date of 7/2011, indicated:</p> <p>a. on page two in the "Applicant Processing" section, it reads in item D. "Hospital, via Evolutions Consulting, conducts a background investigation on all prospective associates after an offer of employment is accepted. This includes, but is not limited to:...EPLS (excluded parties list system)...5. Indiana statewide repositor..."</p> <p>2. at 9:45 AM on 1/15/13 review of personnel files indicated:</p> <p>a. nurse aides P3, P4, P5, P12 and P13 were hired between 12/8/10 and 8/15/12</p>	S000102	<p>Correction: Human Resources Staff has contacted the state nurse aide registry to complete background checks for all non-licensed caregivers. Prevent Recurrence: Human Resources staff use a checklist to track completion of pre-employment activities. Contacting the state nurse aide registry has been added to the checklist. Responsible Party: The Human Resources Assistant has contacted the state nurse aide registry and has also revised the pre-employment checklist. Completion Date: The state nurse aide registry background checks were completed for all current non-licensed caregivers on 2/7/2013. The checklist was revised by 2/7/2013.</p>	02/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and lacked documentation that HR had contacted the state nurse aide registry as part of the background check for employment</p> <p>b. nurse aide P5 was hired 8/9/10, had a background release form signed by the staff person, but lacked any documentation that the background check was made</p> <p>c. high school student (ICE students = Interdisciplinary Cooperative Education) files for staff P12 and P13, who began work on 8/15/12, had background release forms signed, but lacked any documentation that the background checks were made</p> <p>3. interview with staff member #62, the human resources assistant, at 10:30 AM on 1/15/13 indicated:</p> <p>a. the HR (human resources) director is a shared position with another facility- -there is no full time HR director at this facility</p> <p>b. this staff member was unaware of the need to check the state nurse aide registry prior to hire (for those staff members providing hands on patient care, but not licensed)</p> <p>c. this staff member thought it was unnecessary to do background checks on staff members P12 and P13</p> <p>4. interview with staff member # 57, the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>facility nursing educator, at 10:35 AM on 1/15/13 indicated:</p> <p>a. it was thought that the EPLS and "Indiana statewide repositior" listed in the facility policy was the indication that the facility requires the state nurse aide registry check to be done for new nurse aides prior to hire</p> <p>5. interview on 1/15/13 with staff member #51, the chief nursing officer, at 11:45 AM indicated:</p> <p>a. all new hires, including high school ICE students, are to have background checks performed</p> <p>b. it is unknown why staff members P5, P12 and P13 had signed consents for background checks to be performed, but lacked documentation of having this process completed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to maintain its policy/procedure and ensure that all policy/procedures in use were updated and reviewed annually for 16 of 24 policy/procedures reviewed.</p> <p>Findings:</p> <p>1. The administrative policy/procedure Annual Policy Review (last approved 6-06) indicated the following: " Each department and committee responsible for policies and guidelines will set up a time for annual review. Annually all policies will be reviewed. "</p> <p>2. The following department/service/committee policy/procedures failed to indicate an annual review by the responsible person</p>	S000322	<p>Correction: All of the listed policies noted in the formal report will be reviewed and/or revised in PolicyStat, our electronic policy program. Prevent Recurrence: All hospital policies will be reviewed on an annual basis and automated electronic prompts will notify the responsible manager when such policies are due for their annual review/update/revision. Responsible Party: Each department manager will be responsible for reviewing their respective policies. The Hospital administrator will hold ultimate responsibility for ensuring policies are reviewed in a timely fashion. Completion Date: All sixteen of the listed policies will be reviewed and/or revised by 2/28/2013.</p>	02/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>in accordance with hospital policy:</p> <ul style="list-style-type: none"> <li>A. Administration of Drugs (last approved 10-11)</li> <li>B. Adverse Medication Event Reporting (last approved 8-10)</li> <li>C. Cleaning of Operating Rooms by Surgery Staff (last approved 9-11)</li> <li>D. Confidentiality of Medical Record Information (last approved 6-01)</li> <li>E. Crash Cart Maintenance (last approved 10-01)</li> <li>F. Discharge of a Newborn (last approved 7-11)</li> <li>G. Discharge of a Patient (last approved 11-97)</li> <li>H. Discharge of the Post Partum Patient (last approved 7-11)</li> <li>I. Discharge Planning Procedure (last approved 7-01)</li> <li>J. Educational Requirements (last approved 7-11)</li> <li>K. Physician Orders (last approved 6-06)</li> <li>L. Sentinel Event (last approved 10-05)</li> <li>M. Telephone and Verbal Orders (last approved 1-03)</li> <li>N. Terminal Cleaning of Surgery Suite (last approved 7-11)</li> <li>O. Therapy Documentation (last approved 10-11)</li> </ul> <p>3. Review of Radiation Safety Manual indicated signatures of approval by the radiology medical director, the facility administrator, and the department director</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>with a reviewed/approved date of November 2011. The handwritten entry of November 2012 under the printed date failed to indicate that the policy/procedure manual had been reviewed and approved with authentication by the responsible persons.</p> <p>4. During an interview on 1-16-13 at 1330 hours, staff A2 confirmed that the facility failed to assure that its policy/procedures had been reviewed or updated annually in accordance with facility policy.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000392	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(2)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(2) That the services performed under a contract are provided in a safe and effective manner and are included in the hospital's quality assessment and improvement program.</p> <p>Based on document review and interview, the governing board failed to ensure that services provided by agreement were provided in a safe and effective manner and included in the quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. The St Vincent Randolph Performance Improvement Plan (approved 7-12) failed to indicate the requirement for monitoring, evaluating, and reporting the contracted services provided at the facility through its QAPI program.</p> <p>2. On 1-14-13 at 1030 hours, staff A1 and A2 were requested to a list of contracted services and requested to provide documentation of ongoing contracted services monitoring,</p>	S000392	<p>Correction: All contracted services are currently reviewed on an annual basis. A summary of the reviews for 2012 will be submitted to and reviewed by the Patient Safety Council, which serves as our Quality Assurance Committee, before being presented to the Governing Board. Prevent Recurrence: Contracted services will be reviewed on a quarterly basis for the calendar year 2013 using a different format and multiple quality indicators for each specified contract service. The reviews will be presented on a quarterly basis to the Patient Safety Council and subsequently to the Governing Board on a quarterly basis. Department Managers will complete the reviews quarterly. Responsible Party: The Compliance Coordinator will coordinate completion of quarterly reviews and compile the</p>	03/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>performance indicators, and documentation of reporting through the QAPI program and none was provided prior to exit.</p> <p>3. On 1-16-13 at 1125 hours, administrator staff A10 was requested to provide documentation of contracted services evaluation and reporting in the governing board meeting minutes. Staff A10 provided documentation of a list of contracted services and governing board minutes for July 2012 indicating approval of the service agreements. Staff A10 was requested to provide documentation indicating an ongoing review for the listed services in 2012 and none was provided prior to exit.</p> <p>4. During an interview on 1-16-13 at 1215 hours, staff A10 confirmed that no additional documentation was available regarding the evaluation of the contracted services through the QAPI program.</p>		<p>reviews for Patient Safety Council and the Governing Board quarterly. Completion Date: The reviews for 2012 will be presented to the Patient Safety Council on 2/27/2013 and to the Governing Board on 3/26/2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000420	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the hospital:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the hospital.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p> <p>Based on document review and interview, the quality assessment and improvement program failed to assure that all reportable events were identified and reported to the Indiana State Department of Health (ISDH).</p> <p>Findings:</p> <p>1. The policy/procedure Sentinel Events (last approved 10-05) failed to indicate the events required to be reported to the ISDH as described in 410 IAC 15-1.4-2.2(a)(1). Staff A1 and A2 were requested to provide an approved policy/procedure indicating all the required events to be reported and none was provided prior to exit.</p> <p>2. During an interview on 1-16-13 at 1320 hours, staff A1, A2 and A3 confirmed that the policy/procedure failed to indicate the required events to be reported to ISDH.</p>	S000420	<p>Correction: A policy titled 'Reportable Events' will be created and written in such manner that all reportable events will be listed in the policy. Prevent Recurrence: The new policy will be created in PolicyStat, our electronic policy program, and will be reviewed on an annual basis. Responsible Party: The Risk Manager will create and review this policy. Completion Date: The policy will be completed by 2/28/2013.</p>	02/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>identified by a hospital that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2) Based on document review and interview, the facility failed to have a policy/procedure for reporting to the Indiana State Department of Health (ISDH) each reportable event determined by the quality assessment and improvement program to have occurred within the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The St Vincent Randolph Hospital Performance Improvement Plan (approved 7-12) and policy/procedure Sentinel Events (last approved 10-05) failed to indicate a process for reporting each reportable event per 410 IAC 15-1.4-2.2(a)(2).</li> <li>During an interview on 1-16-13 at 1030 hours, staff A1, A2 and A3 confirmed that the plan and policy/procedure lacked a provision for reporting an event to ISDH.</li> </ol>	S000422	<p>Correction: A policy titled 'Reportable Events' has been written and includes the process and time frame for reporting any required reportable event. Prevent Recurrence: The policy was created in PolicyStat, our electronic policy program, with annual review. Staff have been and will continue to be educated on the list of reportable events, the process for reporting and, the time frame for reporting such incidents. Education is done by presentation in the annual associate inservice program. Responsible Person: The Risk Manager conducts this education at the annual associate inservice program. Completion Date: All associates will receive this education through presentation at annual associate inservice by the end of the Fiscal Year, which is 6/30/2013.</p>	06/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review, observation and interview, the facility failed to ensure a safe environment that minimized infection exposure and risk for employees in the housekeeping services area of the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a tour on 1-14-13 at 1545 hours, the following condition was observed in the main housekeeping department: a front-loading Maytag washer immediately next to a frontloading Maytag dryer in an area without a handwashing sink. No degree of separation was observed between the soiled area and the clean area. The washer lacked a feature for elevating the water temperature with an internal heating circuit to sanitize the laundry items. A large dial gauge thermometer was visible immediately behind the washer unit on the water supply line.</li> <li>2. During an interview on 1-14-13 at 1545 hours, staff A5 indicated that no</li> </ol>	S000554	<p>Correction: The washer and dryer were disabled on 2-11-13 and will be removed completely from the facility on 3-1-13. Prevent Recurrence The washer and dryer will be removed from the facility. Responsible Party: The Director of Engineering will ensure the washer and dryer will be removed from the facility. Completion Date: The washer and dryer will be physically removed by 3/1/2013.</p>	02/11/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>temperature monitoring was being performed regarding the microfiber mop heads being washed in the department. Staff A5 confirmed that the washer unit lacked a sanitize cycle feature with a water heater element, confirmed that no hand sink was immediately available in the area for handling soiled items, and confirmed that no separation existed between the soiled and clean areas for items laundered in the department.</p> <p>3. During an interview on 1-15-13 at 1450 hours, staff A12 indicated that the laundry detergent ARA was selected approximately two years ago with input of the Infection Preventionist nurse. Staff A12 confirmed that the ARA laundry detergent MSDS data sheet failed to indicate a significant shift in the alkaline pH range (8.1 to 8.6) for the household laundry detergent when compared with commercial laundry services alkalinity reports (pH &gt; 10.0). Staff A12 confirmed that no bleach was being added to sanitize the wash loads and no temperature monitoring was being conducted at the present time.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000570	<p>410 IAC 15-1.5-2 INFECTION CONTROL</p> <p>410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on review of the facility "Infection Prevention Surveillance Program", review of the 2012 infection prevention committee meeting minutes, and staff interview, the facility and infection control committee failed to ensure that the physician appointed to the committee was an active participant in infection prevention practices of the facility.</p> <p>Findings: 1. at 12:05 PM on 1/14/13, review of the binder related to the 2012 Infection</p>	S000570	Correction: The appointed medical director for the Infection Prevention Committee will be an active participant in the infection prevention practices of the hospital. Prevent Recurrence: Infection Prevention Committee meetings will be scheduled to accommodate the medical director's schedule. Responsible Party: The Infection Preventionist will schedule each of the Infection Prevention Committee meetings to allow and insure that the medical director will attend the meetings. The Infection	02/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Prevention Committee, which included the 2012 "Program" and meeting minutes, indicated:</p> <p>a. the "Infection Prevention Surveillance Program", signed 4/24/12 by the committee physician, indicated in the section titled: "Authority": "The program is overseen by the Infection Prevention Committee headed by an appointed physician, Dr...."</p> <p>b. the physician appointed to the infection prevention committee was absent at 6 of 8 meetings held in 2012 as follows: January 12, 2012; February 9, 2012; March 2012 (two dates found = March 19 on agenda and March 8 on meeting minutes); June 21, 2012; July 12, 2012; and September 20, 2012</p> <p>2. at 2:40 PM on 1/14/13 and 12:15 PM on 1/15/13, interview with staff member #52, the infection control preventionist, indicated:</p> <p>a. the physician appointed to the infection prevention committee is also the hospitalist and unable to attend all infection prevention meetings</p> <p>b. it cannot be determined, due to the absence of the physician, that the infection prevention committee is fully functioning and effective</p> <p>c. the "Infection Prevention Surveillance Program" cannot be fully implemented with the absence of the</p>		<p>Preventionist will audit the attendance of the medical director with the goal of attending 75% of the meetings for the year. Completion Date: Scheduling of the monthly Infection Prevention Committee Meetings will be complete by 2/28/2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>appointed medical director of the program</p> <p>d. it is thought that at some meetings, the physician entered the meetings late and was therefore not counted in attendance</p> <p>3. interview with staff member #51, the chief nursing officer, at 12:15 PM on 1/15/13 indicated:</p> <p>a. the physician appointed to the infection prevention meeting is to have been in attendance at these meetings</p> <p>b. it is not clear if this physician's peer review process includes the monitoring of their attendance at the infection prevention meetings, or just at medical staff meetings</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</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>(i) Sanitation. Based on document review and interview, the infection control (IC) committee failed to maintain its sanitation policy/procedures and ensure that the operating room (OR) cleaning and disinfecting was performed in a safe and effective manner.</p> <p>Findings:</p> <p>1. The housekeeping policy/procedure Terminal Cleaning of the Surgery Suite (last approved 7-11) failed to indicate the following: A documentation of policy/procedure review and approval by the IC committee B organization of policy content appropriate for the target personnel C protective clothing to be worn by</p>	S000592	<p>Correction: The policy is being updated by the Environmental Services Manager detailing the tasks and processes for terminal cleaning in the Operating Room. This policy will be formally reviewed and approved by the Infection Prevention Committee. Prevent Recurrence: Observations of Environmental Services staff performing terminal cleaning tasks will be conducted by the departmental manager in conjunction with the Infection Preventionist to ensure terminal cleaning is being performed appropriately. <b>Responsible Party:</b> The Environmental Services Manager will create the policy for terminal cleaning. The Infection Prevention Committee will review the policy for appropriate measures and the</p>	04/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>cleaning personnel in restricted and semi-restricted areas</p> <p>D products used for disinfecting surfaces and mopping including wet contact time and changing frequency</p> <p>E general IC guidelines (clean from high to low and least contaminated to most contaminated)</p> <p>F a provision ensuring that all high-touch surfaces were cleaned and/or disinfected</p> <p>G a specific Terminal OR cleaning process to prevent contamination of previously disinfected surfaces</p> <p>H an organized sequence for restricted area cleaning to minimize traffic in the surgery area</p> <p>2. During an interview on 1-15-13 at 1030 hours, the Infection Preventionist staff A9 confirmed that the policy/procedure lacked documentation of review and approval by the Infection Control / Patient Care Committee and confirmed that the policy/procedure lacked the indicated provisions to prevent contamination of previously disinfected surfaces by contracted housekeeping personnel. Staff A9 confirmed that no observations of the Terminal OR cleaning by contracted service housekeeping personnel had been performed by the Infection Preventionist in 2012.</p>		Infection Preventionist will monitor compliance with the policy. Completion Date: The updated policy will be reviewed by the Infection Prevention Committee on 2-21-13.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on policy and procedure review, observation and interview, the infection control committee failed to ensure the cleanliness of surfaces and appliances in four areas toured (emergency department crash cart, surgery pantry, and med/surg pantry and clean utility room).</p> <p>Findings:</p> <p>1. at 11:35 AM on 1/15/13, review of the Steris "Amsco Warming Cabinet" manual indicated in the "Preventive Maintenance" section (4-1) that cleaning is "As required" and not specific to any routine process</p> <p>2. at 1:15 PM on 1/14/13, while on tour of the ED (emergency department), in the company of staff member # 56, the ED</p>	S000596	<p>Correction: Warming cabinet temperatures are checked and recorded daily and the warming cabinets will be specifically cleaned on a monthly basis. The Emergency Room crash cart will be cleaned by the Emergency Room staff on a weekly basis. Refrigerator and freezer temperatures are checked and recorded daily. Refrigerators and freezers are cleaned weekly. All microwaves are cleaned as needed. The policy currently in place entitled 'Temperature Checks' will be revised to include specific, periodic cleaning of refrigerators, warming cabinets and microwaves. Prevent Recurrence: Cleaning the Emergency Room crash cart will be added to the crash cart checklist. Cleaning schedules for</p>	02/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>manager, it was observed that the top of the emergency crash cart in trauma room #1 had accumulated dust on the top of the cart</p> <p>3. interview with staff member #56 at 1:20 PM on 1/14/13 confirmed the presence of accumulated dust and the failure of ED staff to monitor the cleanliness of the cart</p> <p>4. at 9:30 AM on 1/15/13, while on tour of the surgery area pantry in the company of staff member #54, the surgery manager, it was observed that:</p> <p>a. the Steris (Amsco) blanket warmer had a buildup of dried liquid, or other crusty material/debris, on the bottom shelf of the counter top model (under the plenum shelf)</p> <p>b. the employee refrigerator freezer compartment had a grated/grill attachment to the bottom shelf of the compartment in which fluids had dripped and food debris had collected</p> <p>5. interview with staff member #54 at 9:35 AM on 1/15/13 indicated it was unknown:</p> <p>a. there was an attachment in the freezer that could be removed for better cleaning</p> <p>b. that a build up had occurred in the blanket warmer</p>		<p>the refrigerators, freezers, microwaves and warming cabinets has been added to the temperature check logs. Responsible Party: The Emergency Room Nurse Manager will revise the Emergency Room crash cart checklist to include cleaning the crash cart. The Infection Preventionist has added the cleaning schedule to the temperature check logs. Department Managers are responsible for ensuring cleaning of appliances is performed. Completion Date: All revised checklists and temperature check logs will be in place by 2/28/2013.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>6. at 9:55 AM on 1/16/13, while on tour of the medical/surgical pantry in the company of staff member #58, the med/surg nursing manager, it was observed that:</p> <ul style="list-style-type: none"> <li>a. the patient refrigerator freezer compartment had a grated/grill attachment to the bottom shelf of the compartment in which food debris had collected</li> <li>b. the microwave oven had spattered food/liquid on the walls, ceiling, and door of the unit</li> </ul> <p>7. at 10:00 AM on 1/16/13, interview with staff member #58 indicated:</p> <ul style="list-style-type: none"> <li>a. it was unknown there was an attachment in the freezer that could be removed for better cleaning</li> <li>b. the microwave has been on a "clean as needed" basis that is not working at this time</li> </ul> <p>8. at 10:10 AM on 1/16/13, while on tour of the medical/surgical clean utility room in the company of staff member #58, the med/surg nursing manager, it was observed that the microwave used to warm the bags of bath cleaning products was filled with accumulated dust particles in the door and around the glass turntable</p> <p>9. interview with staff member #58 at</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>10:15 AM on 1/16/13 indicated:</p> <ul style="list-style-type: none"> <li>a. it was unknown that the bath products emitted a dusty exhaust that covered the interior of the microwave</li> <li>b. the dusty microwave is both an infection control issue as well as a fire precaution</li> <li>c. the microwave is not currently on any type of routine cleaning schedule</li> </ul> <p>10. interview with staff member #51, the chief nursing officer, at 9:15 AM on 1/16/13 indicated there is currently no facility policy that addresses routine cleaning of refrigerators, microwaves and blanket warmers located through out the facility</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000672	<p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(e)</p> <p>(e) All nursing and other hospital personnel performing out-of-laboratory testing shall have annually updated performance certification maintained in the employee file for the procedures being performed.</p> <p>Based on personnel file review and staff interview, the facility failed to ensure that point of care testing for glucometer checks performed by nursing staff had annual performance competency assessed for 10 of 10 RNs (registered nurses) and nurse aides. (staff members P1 through P10)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>at 9:45 AM on 1/15/13 review of personnel files indicated: <ol style="list-style-type: none"> <li>staff RNs and nurse aides P1 through P10 were hired in 2010 and 2011 and had documentation of annual skills competency but lacked any documentation of competency assessment for point of care testing related to the patient glucometer checks performed by these staff persons</li> </ol> </li> <li>interview with staff member # 57, the nursing educator, at 10:30 AM on 1/15/13 indicated: <ol style="list-style-type: none"> <li>skills competency checks for nursing staff performing bedside glucometer</li> </ol> </li> </ol>	S000672	<p>Correction: All nursing staff will attend education on glucometer checks. All nursing staff will complete a skills competency check off as part of the education. Prevent Recurrence: Annual skills competency checks will be performed for all nursing staff. Staff will scan the bar codes on their name badges with the glucometer scanner when completing the skills competency check as proof of completing education. Staff competency renewal dates can be tracked by electronic reports uploaded from the glucometers. Responsible Party: The Clinical Nurse Educator and the Diabetes Educator will be conducting the education and competency checks. Completion Date: The education and competencies for all registered nurses will be completed by 3/15/2013.</p>	03/15/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	checks for patients are not currently being performed--staff is trained and checked off on performance at the time of hire, but not assessed again for continued competency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on review of medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure that medical records were complete for 5 of 15 patient records reviewed. (pts. #3, 5, 6, 8, and 9)</p> <p>Findings:</p> <p>1. at 9:40 AM on 1/16/13, review of the medical staff rules and regulations, with an approved date of 7/2009, indicated:</p> <p>a. on page 17 in the section titled "Medical Records and Documentation", it reads: "The Attending Physician and Consulting Staff are responsible for the preparation of a complete, legible and accurate medical record..."</p> <p>2. review of patient medical records at 9:45 AM on 1/15/13 indicated:</p> <p>a. pt. #3 had a transfer form that lacked completion in the areas:</p> <p>I. "Patient status at time of transfer: Non-Emergent Emergent Urgent" (the status was not documented)</p> <p>II. "Vital Signs Prior to Transfer:..."</p>	S000744	<p>Correction: The Emergency Department Nurse Manager will complete education with Emergency Department Staff regarding appropriate completion of any and all patient Transfer Forms. The Emergency Department Nurse Manager will re-educate the Emergency Department physicians to appropriately date and time all orders on such transfer forms. Prevent Recurrence: Concurrent chart reviews will be conducted to ensure completion of the Emergency Department documentation. Random review will be conducted by the Emergency Department Nurse Manager. Responsible Party: The Emergency Department Nurse Manager will conduct all education and instruct staff on conducting concurrent chart audits. Completion Date: The education will be complete by 2/20/2013.</p>	02/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>b. pt. #5 had a transfer form that lacked completion in the areas:</p> <p>I. "Patient status at time of transfer: Non-Emergent Emergent Urgent" (the status was not documented)</p> <p>II. "Medications Given" and "Treatment Given"</p> <p>c. pt. #6 lacked a date and time of physician authentication of admission orders</p> <p>d. pt. #8 lacked the documentation of time:</p> <p>I. at the top of the admission order page</p> <p>II. with the physician authentication of admission orders</p> <p>e. pt. #9 had a transfer form that lacked completion in the area: "Patient status at time of transfer: Non-Emergent Emergent Urgent" (the status was not documented)</p> <p>3. interview with staff member #51, the chief nursing officer, at 9:00 AM on 1/16/13 indicated:</p> <p>a. the medical records, as listed in 2. above, were lacking completion of documentation</p> <p>b. standing orders have a specific place for physicians to date and time their</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	authentication of orders (at the bottom of the order form) c. it is expected that physicians date and time their authentication of orders				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000868	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed: (i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff; (ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or (iii) within forty-eight (48) hours after an admission.</p> <p>Based on review of the medical staff rules and regulations, surgery patient medical record review, and staff interview, the medical staff failed to ensure the implementation of its rules and regulations, related to history and physical examinations prior to surgery, for 1 of 4 surgery charts reviewed. (pt. #12)</p> <p>Findings: 1. at 9:40 AM on 1/16/13, review of the Medical Staff Rules and Regulations, last approved July 2009, indicated: a. on page 17, in the section "Medical Records and Documentation", it reads:</p>	S000868	Correction: Surgery Staff will be re-educated regarding an appropriate History and Physical being a required document prior to performing any surgical procedure. Checking the chart for an appropriate History and Physical is part of the pre-surgery time-out procedure. Prevent Recurrence: The Surgery Nurse Manager will perform a chart audit of 100% of Surgery charts for 30 days. The compliance goal is 100%. Responsible Party: The Surgery Nurse Manager will conduct the education and perform the chart audits. Completion Date: The	03/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"A complete history and physical should be dictated...Surgical patients...are required to have a history and physical dictated and transcribed prior to the surgical procedure. If a history and physical has been completed within 30 days of the admission, a durable, legible copy of this report may be used..."</p> <p>2. at 1:00 PM on 1/16/13, review of surgery patient medical records #12 to #15 indicated:</p> <p>a. pt. #12 had surgery on 11/13/12 for an acute medial meniscus tear and had a history and physical dated 10/11/12 in the medical record</p> <p>3. interview with staff member #54, the surgery manager, at 1:30 PM on 1/16/13 indicated:</p> <p>a. the history and physical for patient #12 was beyond the 30 day requirement of the medical staff rules and regulations</p> <p>b. surgery staff should have realized the dictated history and physical was beyond the 30 days and required the surgeon to dictate a new history and physical or complete the one page brief form accepted by the facility</p>		education will be completed by 2/20/2013.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000871	<p>410 IAC 15-1.5-5 Medical Staff 410 IAC 15-1.5-5(b)(3)(O)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual receiving a verbal order shall date, time, and sign the verbal order in accordance with hospital policy. Authentication of a verbal order must occur within forty-eight (48) hours unless a read back and verify process described under items (i) and (ii) is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge.</p> <p>(i) As an alternative, hospital policy may provide for a read back and verify process for verbal orders. Any read back and verify process must require that the individual receiving the order shall immediately read back the order to the ordering physician or other responsible individual who shall immediately verify that the read back order is correct.</p> <p>(ii) The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. Where the read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on policy and procedure review, review of medical staff rules and regulations, patient medical record review, and staff interview, the medical staff failed to ensure that nursing staff implemented facility policy related to correct documentation of telephone and/or verbal orders for 3 patient medical records (pts. #1, 8, and 9), and medical staff failed to ensure that physicians are dating and timing authentication of verbal/telephone orders to validate authentication within 24 hours as required.</p> <p>Findings:</p> <p>1. at 9:15 AM on 1/16/13, review of the policy and procedure "Telephone and Verbal Orders", with a policy number of 74877 and a most recent review date of 11/19/12, indicated:</p> <p>a. in the section titled "Implementation", it reads: "...2. When the physician has indicated that the list of orders is completed, indicate to the physician that the orders will be repeated back. 3. Read all orders as written to confirm accuracy...5. Orders not confirmed by reading orders back...will not be implemented...9. When signing off verbal or telephone orders, the person receiving the orders will document and sign that all orders were read back and confirmed."</p>	S000871	<p>Correction: Nursing Staff are using the abbreviation "RBV" after their names at the end of the Telephone or Verbal Order. Nursing Staff have been educated on the new procedure. The Medical Staff Rules and Regulations will be modified to correspond to 410 IAC 15-1.5-5 regarding authentication guidelines. Prevent Recurrence: The stamp that had been used will be removed from the Nursing Units. Concurrent chart audits will be completed by the Med/Surg Nursing Staff. 100% of charts will be audited for 30 days. The compliance goal is 100%. Responsible Party: The Med/Surg Manager has already completed the education of nursing staff on using 'RBV' after their names at the end of the Telephone or Verbal Order. <b>Completion Date:</b> Education of nursing staff was completed on 1/22/2013. The concurrent chart audit will be completed by 3/31/2013. The modification to the Medical Staff Rules and Regulations will be reviewed and approved at the Medical Staff meeting on 3/12/2013.</p>	03/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. at 9:40 AM on 1/16/13, review of the Medical Staff Rules and Regulations, last approved July 2009, indicated:</p> <p>a. on page 19, in section "Physician's Orders", it reads: "...Verbal orders should be countersigned by the prescribing physician within 24 hours..."</p> <p>3. review of medical records through out the survey process of 1/14/13 to 1/16/13 indicated:</p> <p>a. pt. #1:</p> <p>I. had telephone orders written on 1/13/13 at 0946 hours that lacked documentation by nursing staff of having been read back and verified by the person taking the order</p> <p>II. had authentication by the physician of telephone orders taken on 1/13/13, but lacked dating and timing to confirm that the authentication occurred within 24 hours of the telephone orders</p> <p>b. pt. #8 had:</p> <p>I. telephone orders written on 9/6/12 at 2008 hours, 2045 hours, and 2225 hours and on 9/7/12 at 0720 hours, that lacked documentation by nursing staff of having been read back and verified by the person taking the order</p> <p>c. pt. #9 had:</p> <p>I. verbal orders written on 11/3/12 at 1600 hours and on 11/4/12 at 1410 hours and 1845 hours that lacked documentation by nursing staff of having</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>been read back and verified by the person taking the order</p> <p>II. authentication by the physician of verbal orders taken 11/3/12 and 11/4/12, but lacked dating and/or timing to confirm that the authentication occurred within 24 hours of the telephone orders</p> <p>4. interview with staff member #51, the chief nursing officer, at 9:00 AM on 1/16/13 indicated:</p> <p>a. the facility has provided nursing staff with a stamp that is to be applied to physician order pages when telephone or verbal orders are documented</p> <p>b. the stamp, with areas to be completed by nursing staff, is the indication that nurses read back and verified the telephone or verbal orders</p> <p>c. the facility policy does not require that the stamp be utilized, but that there is some type of documentation by nursing that telephone or verbal orders were verified</p> <p>d. the patient charts for pts. #1, 8 and 9 are lacking documentation by nursing staff that verbal or telephone orders were read back and verified, as required by facility policy</p> <p>e. it is a struggle to get the physicians to date and time authentication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000912	<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 areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the nursing executive failed to ensure that nursing staff implemented policies related to: pediatric assessment</p>	S000912	Correction: Med/Surg Nursing Staff will be re-educated on the following: - Staff must measure height and head circumference for all pediatric patients less than 2 years of age at the time of	03/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>on admission for 2 of 3 patients 4 years and younger (pts. # 6 and 7); fall risk assessment on admission for 1 of 2 open records of patients (pt. #11); and correct documentation of telephone and/or verbal orders for 3 patient medical records. (pts. #1, 8, and 9)</p> <p>Findings:</p> <p>1. at 9:15 AM on 1/16/13, review of the policy and procedure "Documentation - Pediatric", with a policy number of 84138, and a last reviewed date of 11/19/12, indicated:</p> <p>a. on page one under "Rational", it reads: "These assessment tools are to be used for children under age 16...The admission assessment is to be completed within the first hour the child is admitted to the medical surgical nursing unit..."</p> <p>b. on page 4 under the section "Implementation &amp; Documentation:", it reads: "A. Admission Assessment form...C. Graphic Record:...3. If appropriate to the patient's condition record the patient's weight, abdominal circumference and head circumference by writing the data in appropriate boxes..."</p> <p>2. at 3:45 PM on 1/14/13, review of the policy and procedure "Fall Potential Assessment", with a policy number 74350 and an effective date of 11/1997, indicated:</p>		<p>admission. - Staff must complete a Fall Risk Assessment for all patients as part of the admission process. - Staff must use the abbreviation "RBV" after their names to signify that a Telephone or Verbal Order has been read back to the ordering physician and verified by that physician. Prevent Recurrence: A concurrent chart audit will be performed for pediatric height and head circumference. The audit will include all pediatric patient charts for 30 days. The compliance goal is 100%. A concurrent chart audit will be performed for fall risk assessments on all charts for 30 days. The compliance goal is 100%. A concurrent chart audit will be performed for the read back and verify process for telephone and verbal orders. All charts will be audited for 30 days with a compliance goal of 100%. Responsible Party: The Med/Surg Nurse Manager has completed education on the read back and verify process. Re-education on measuring height and head circumference of pediatric patients and completing the fall risk assessment for all patients will also be completed by the Med/Surg Nurse Manager. Completion Date: All education and chart audits will be completed by 3/31/2013.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>a. on page one under "Implementation", it reads: "1. Assessment will be done on every patient admitted medical/surgical as an in patient or swing bed patient..."</p> <p>3. at 9:15 AM on 1/16/13, review of the policy and procedure "Telephone and Verbal Orders", with a policy number of 74877 and a most recent review date of 11/19/12, indicated:</p> <p>a. in the section titled "Implementation", it reads: "...2. When the physician has indicated that the list of orders is completed, indicate to the physician that the orders will be repeated back. 3. Read all orders as written to confirm accuracy...5. Orders not confirmed by reading orders back...will not be implemented...9. When signing off verbal or telephone orders, the person receiving the orders will document and sign that all orders were read back and confirmed."</p> <p>4. at 1:00 PM on 1/15/13, review of pediatric medical records indicated:</p> <p>a. pt. #6 was a 1 year old admitted 1/7/12 who lacked documentation of either a height or head circumference measurement</p> <p>b. pt. #7 was a 1 year old admitted 3/11/12 who lacked documentation of a head circumference measurement</p> <p>5. interview with staff member #58, the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>medical/surgical nursing manager, at 1:30 PM on 1/15/13 indicated:</p> <p>a. it is expected that height and head circumference will be measured, along with weight, on all children less than 2 years of age at the time of admission to the unit</p> <p>6. at 10:00 AM on 1/16/13, while on tour of the medical/surgical nursing unit, open medical records were reviewed and indicated:</p> <p>a. pt. #11 was admitted on 1/15/13 and lacked the completion of the Fall Risk Assessment tool titled "Assessment of Fall Potential" for that day</p> <p>7. At 10:05 AM on 1/16/13, interview with staff member #58, the medical/surgical nursing manager, confirmed that, even though the patient was placed on high risk precautions for a fall, the "Assessment of Fall Potential" form was not completed on 1/15/13, as required by facility policy</p> <p>8. review of medical records through out the survey process of 1/14/13 to 1/16/13 indicated:</p> <p>a. pt. #1 had telephone orders written on 1/13/13 at 0946 hours that lacked documentation by nursing staff of having been read back and verified by the person taking the order</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>b. pt. #8 had telephone orders written on 9/6/12 at 2008 hours, 2045 hours, and 2225 hours and on 9/7/12 at 0720 hours, that lacked documentation by nursing staff of having been read back and verified by the person taking the order</p> <p>c. pt. #9 had verbal orders written on 11/3/12 at 1600 hours and on 11/4/12 at 1410 hours and 1845 hours that lacked documentation by nursing staff of having been read back and verified by the person taking the order</p> <p>9. interview with staff member #51, the chief nursing officer, at 9:00 AM on 1/16/13 indicated:</p> <p>a. the facility has provided nursing staff with a stamp that is to be applied to physician order pages when telephone or verbal orders are documented</p> <p>b. the stamp, with areas to be completed by nursing staff, is the indication that nurses read back and verified the telephone or verbal orders</p> <p>c. the facility policy does not require that the stamp be utilized, but that there is some type of documentation by nursing that telephone or verbal orders were verified</p> <p>d. the patient charts for pts. #1, 8 and 9 are lacking documentation by nursing staff that verbal or telephone orders were read back and verified, as required by facility policy</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the facility failed to ensure that no hazard may result for patients in relation to expired supplies/products in two areas toured. (emergency department and surgery store room)</p> <p>Findings:</p> <p>1. at 1:20 PM on 1/14/13, while on tour of the ED (emergency department) in the company of staff member #56, the ED manager, it was observed that the Toomey syringe in the crash cart from trauma room #2 had expired 12/12</p> <p>2. interview with staff member #56 at 1:25 PM on 1/14/13 confirmed that the syringe in the crash cart was expired and that ED staff had recently checked the cart for expired supplies and had missed this item</p>	S001118	<p><b>Correction:</b> A policy entitled "Expired Supplies" will be created and applied to all departments. All associates will be re-educated on the importance of thoroughly checking for expiration dates. Prevent Recurrence: Documentation of checking for expired supplies will be maintained in each department. Random checks for expired supplies will be conducted once a week for one month. Responsible Party: The Compliance Coordinator will create the "Expired Supplies" policy. Department managers will perform random checks of supplies for expiration dates. Completion Date: All education and random checks for expired supplies will be completed by 3/31/2013.</p>	03/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. at 9:15 AM on 1/15/13, while on tour of the surgery store room in the company of staff member #54, the surgery manager, it was observed that the following sutures were expired:</p> <ul style="list-style-type: none"> <li>a. 10 packages of 2 - 0 Vicryl that expired July 2012</li> <li>b. 7 packages of 6 - 0 Vicryl that expired January 2012</li> </ul> <p>4. interview with staff member #54 at 9:20 AM on 1/15/13 indicated staff have taken suture packets from almost empty boxes and placed them in newly opened boxes, but the expiration dates are not compatible and the added sutures have then expired prior to being utilized</p> <p>5. no policy was provided related to stock rotation and routine checking for expired supplies on nursing units</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S001164	<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.</p> <p>Based on policy and procedure review, observation, and staff interview, the facility failed to implement its policy related to the inspection of new equipment prior to placing it in use for two Welch Allyn vital signs monitors on the medical/surgical nursing unit.</p> <p>Findings: 1. at 1:55 PM on 1/16/13, review of the policy and procedure (no policy number) "Medical Equipment Management Plan", with a most recent approval date of 2/12, indicated: a. under "2. Device Monitoring", it reads: "A. The Hospital will contract with an outside bio-medical engineering vendor... to provide a systematic and continuous monitoring procedure to assure a safe environment and associate safety awareness regarding the use of any bio-medical device...All new bio-medical</p>	S001164	<p>Correction: The two Welch Allyn devices had been inspected by the bio-medical engineer on 12/7/2012. However the engineer failed to attach the labels signifying the equipment was ready for use and the engineer failed to complete his corresponding paperwork until 1/17/2013. Prevent Recurrence: All clinical managers have been re-educated to ensure all appropriate work has been completed and that signifying labels have been affixed to any new equipment prior to being used for patient care. Responsible Party: All clinical department managers will be responsible to ensure all appropriate work has been completed and signifying labels have been affixed to all new medical equipment. Completion Date: The two Welch Allyn devices were checked on 1/17/2013.</p>	01/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>equipment must be inspected by a bio-medical engineer prior to any use..."</p> <p>2. at 10:15 AM on 1/16/13 while on tour of the medical surgical nursing unit in the company of staff member #58, the nursing manager, it was observed that two Welch Allyn vital signs monitors in one patient room, with asset tag numbers 894691 and 894690, had no documentation of a last PM (preventive maintenance) check</p> <p>3. at 10:20 AM on 1/16/13, interview with staff member #58 indicated:</p> <p>a. the two vital signs monitors were new and staff have been trained in the use of this equipment</p> <p>b. it was thought that the contracted bio-medical service provider had checked out the equipment for use</p> <p>4. at 1:50 PM on 1/16/13, interview with staff member #51, the chief nursing officer, indicated:</p> <p>a. the bio-medical contract group assembled the two Welch Allyn vital signs monitors and placed asset tags on them, but failed to provide the preventive maintenance review needed for new equipment at that same time</p> <p>b. the facility policy related to completing the PM process on new equipment before placing it into service</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was not followed for the vital signs monitors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S001168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the hospital failed to maintain its policy/procedure and ensure that defibrillator inspection and testing was performed according to the manufacturer's recommendations for 3 of 5 defibrillators.</p> <p>Findings:</p> <p>1. The policy/procedure Crash Cart Maintenance (expired 10-02) indicated the following: " A test load on defibrillator is to be completed once each 24 hour period (beginning at midnight) that the defibrillator is in use (area/department open). " The policy/procedure failed to ensure that all defibrillators will be discharged in accordance with the manufacturer ' s recommendations for the different defibrillators in use at the facility.</p> <p>2. The Agilent/Phillips M4735A</p>	S001168	<p>Correction: For the LifePak 12 defibrillator, the Operator's Checklist is being used to indicate that the checks are performed according to the manufacturer's recommendations in Surgery and Respiratory Therapy. For the Agilent/Philips defibrillator, a checklist is being created with all of the requirements listed in the Operator's Manual. Prevent Recurrence: The checklist provided in the LifePak 12 Operator's Manual will be used for the LifePak 12 defibrillators. The newly created checklist for the Agilent/Philips defibrillator will be used for the Agilent/Philips defibrillator. Responsible Party: The Clinical Nurse Educator and the Emergency Department Nurse Manager have ensured that the appropriate checklists are attached to each of the LifePak 12 defibrillators and will also ensure the newly created checklist will be appropriate for the Agilent/Philips defibrillator. Completion Date: The correct checklists will be attached</p>	02/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Defibrillator/Monitor (2006) Instructions for Use indicated the following: "</p> <p>perform a Shift/System Check every shift ...When it is done, a report is printed.</p> <p>...The Shift/System Check report lists the results of the test and additional checks that you should do. Perform each of these checks and record the results. "</p> <p>3. During a tour of the Emergency Department (ED) on 1-14-13 at 1445 hours, an Agilent/Phillips M4735A defibrillator was observed in each of Trauma rooms. The document Crash Cart Check Off Trauma 1 failed to indicate that defibrillator checks were performed each shift (minimum 2 times in 24 hours). The check off documentation failed to include the Shift/System Check reports or indicate that the additional checks listed on the report were completed with acceptable results according to the manufacturer ' s recommendations.</p> <p>4. The requested document Crash Cart Check Off Med/Surg Adult December 2012 failed to indicate that checks for the unit M4735A defibrillator were performed each shift and failed to indicate the Shift/System Check report or indicate that the additional checks were completed and acceptable.</p> <p>5. During an interview on 1-15-13 at</p>		to each defibrillator on 2/28/2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1245 hours, staff A5 confirmed that the documentation failed to validate the performance of the additional checks listed on the Shift/System Check report for the defibrillator and confirmed that the policy/procedure had not been maintained.</p> <p>6. During a tour of the Respiratory Therapy Department on 1-14-13 at 1515 hours, a Medtronic Lifepak 12 monitor/defibrillator was observed in the treadmill testing room. No LifePak 12 Operator ' s Checklist (found in the Operators Manual under the chapter heading Maintaining the Equipment) was observed on or around the Crash Cart. The document Crash Cart Check Off Respiratory located on the Crash Cart failed to indicate that the checks were performed according to the manufacturer ' s recommendations and failed to incorporate or attach the manufacturer's Operators Checklist.</p> <p>7. During an interview on 1-14-13 at 1515 hours, staff A5 confirmed that the documentation failed to validate the performance of the defibrillator checks in accordance with manufacturer ' s recommendations.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S001504	<p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(a)</p> <p>(a) If a hospital provides a community emergency service, the service shall meet the emergency needs of the patients served, within the scope of the service offered, in accordance with acceptable standards of practice, and be under the direction of a physician qualified by education or experience.</p> <p>Based on document review and interview, the facility failed to ensure that the emergency department (ED) services were provided under the direction of a credentialed medical staff qualified by training and experience.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of a list of credentialed medical staff failed to indicate the name MD20 of the acting ED medical director. On 1-14-13 at 1300 hours, staff A10 was requested to provide a credential file for the current ED medical director MD20 and none was provided prior to exit.</li> <li>During an interview on 1-16-13 at 1045 hours, staff A3 indicated that the prior ED medical director MD19 notified the physician group chairman MD20 at the end of October 2012 of their intention to vacate the facility position at the end of</li> </ol>	S001504	<p>Correction: The Interim Emergency Department Medical Director is currently on the Active Medical Staff Roster at St Vincent Indianapolis Hospital. He has been granted temporary privileges and is currently completing the credentialing process at St Vincent Randolph Hospital. Prevent Recurrence: The Interim Emergency Department Medical Director will be on a two year re-credentialing cycle. Responsible Party: The Credentialing Committee will ensure completion of the credentialing and re-credentialing process for the Interim Emergency Department Medical Director. Completion Date: The credentialing file for the Interim Emergency Department Medical Director will be presented to the Medical Staff on 3/12/2013.</p>	03/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151301	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT RANDOLPH HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 473 E GREENVILLE AVE WINCHESTER, IN 47394
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>November 2012.</p> <p>3. Review of credential committee meeting minutes dated 11-01-12 and 12-06-12 failed to indicate the pending departure of MD19 or discussion of pending appointment and review or approval of MD20 for medical staff membership.</p> <p>4. During an interview on 1-15-13 at 1730 hours, staff A10 confirmed that physician group chairman MD20 was not a credentialed member of the medical staff at the facility</p> <p>5. During an interview on 1-16-13 at 0925 hours, staff A10 indicated that MD20 had attended last week ' s medical staff meeting as the acting ED medical director. Staff A10 was requested to provide documentation of the medical staff meeting minutes and none was provided prior to exit.</p>			