

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150022	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
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S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 10/26/2015 to 10/28/2015 Facility Number: 005021 QA: cjl 12/04/15	S 0000		
S 0178 Bldg. 00	410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a) (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system. Based on observation and interview, the hospital failed to ensure the hospital license was conspicuously posted for patient viewing at 4 of 4 offsite locations. Findings include: 1. During the tour of the Cancer Center	S 0178	Responsible Person: Director of QualityLicensure copies have been posted in four of four offsite locations. This was completed prior to the end of the survey - 10/28/2015.Pictures of the posted licensure in the four areas are attached for review.	10/28/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>offsite at 2:00 PM on 10/26/2015, the offsite was observed not posting the hospital license for patient viewing.</p> <p>2. During the tour of Franciscan St. Elizabeth Health Diagnostic & Surgery Center offsite at 2:30 PM on 10/26/2015, the offsite was observed not posting the hospital license for patient viewing.</p> <p>3. During the tour of Franciscan St. Elizabeth Health Sleep Lab offsite at 2:45 PM on 10/26/2015, the offsite was observed not posting the hospital license for patient viewing.</p> <p>4. At 3:00 PM on 10/26.2015, staff member #5 (Director of Quality and Performance Improvement) confirmed the license was not posted at any of the four offsite locations: Cancer Center, Franciscan St. Elizabeth Health Diagnostic & Surgery Center, Franciscan St. Elizabeth Health Sleep Lab, and Franciscan St. Elizabeth Health Sports Therapy & Rehab.</p>			

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S 0604 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vii)</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>(vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases. Based on document review and staff interviews, the infection control committee failed to ensure documentation of annual tuberculosis survey completion per policy/procedure for 1 of 9, P14, personnel reviewed.</p> <p>Findings include: 1. A policy/procedure titled: "Tuberculosis Testing Procedure: Procedure Number: 952-11-03, effective 5/2/2013," read: "II Ongoing Screening of Employees, A. Annual questionnaires will be completed by all staff, B. The need for TST or IGRA testing will be determined by the annual risk assessment as outlined by the CDC."</p>	S 0604	<p>Policy review will be completed by 12/31/2015. Responsible Party: Manager of Employee Health. Policy revisions (if indicated) will be completed by 1/31/2016. Responsible Party: Manager of Employee Health. Communicable disease immunization files for the identified deficit area will be reviewed for compliance with guidelines. Completed by 1/31/2016. For any files not meeting compliance, the Employee Health office will ensure notification to the employee, order the testing and collect the specimen/information as appropriate. These steps will be completed within 30 days of identification of noncompliance.</p>	03/31/2016	

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S 0612 Bldg. 00	<p>2. Review of 9 personnel files revealed staff person P14 did not have a completed annual tuberculosis survey as required.</p> <p>3. In interview on 10/27/15 at 3:45 p.m. staff person P18 confirmed the contracted laboratory service did not have the tuberculosis survey for P14, and at 3:50 p.m. staff person 5 also confirmed the facility did not have the tuberculosis survey for P14.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (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>(xi) A program of linen management for personnel involved in linen handling. Based on observation and interview, the hospital failed to ensure storage of clean linen and laundry were in a clean and sanitary environment in the Laundry Department's Sorting Room.</p>	S 0612	<p>Compliance is expected to occur no later than 3/31/2016. Responsible party: Employee Health Manager. A checklist will be utilized to ensure compliance with communicable disease history. Checklists will be used for each new hire following approval of the revised policy. The estimated approval date will be on or before 3/31/2016 . Responsible party: Employee Health Manager.</p> <p>Responsible Persons: Manager of Laundry Services and Manager of Infection Control. Open storage compartments have covers as of 12/1/2015. These will be replaced with new carts having zippered covers. The goal is to have the</p>	01/31/2016

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	<p>Findings include:</p> <p>1. During the tour of the Laundry Department's Sorting Room at 2:20 PM on 10/27/2015, clean and folded uncovered assorted linen was stored in a room where there were leaves on the floor and shelves; dust and dirt debris on the clean linen storage shelves. The door to the sorting room opens to the outside and it was observed with leaves blown from the outside into the sorting room. An uncovered linen transport cart was observed in the sorting room with a leaf on the inside of the cart on a clean linen. Three linen storage racks in the sorting room were observed not covered and half of the linen on the storage shelves were not covered or protected from contaminants.</p> <p>2. In interview at 2:40 PM on 10/27/2015, staff member #3 (Maintenance Supervisor) indicated the Laundry Department's Sorting Room was for clean linen to be stored after it has been processed. The staff member confirmed the sorting room was not maintained in a clean and sanitary manner while storing the clean linen and laundry.</p>		<p>new carts in place by 1/31/2016. The folding/sorting area cleaning schedule will be revised to include daily shelf and floor cleaning. This will be completed by 1/31/2016. The folding/sorting tables will be covered when not in use and prior to the opening of any exterior doors. This will start 12/23/2015. Long term goal is to evaluate facility remodeling options to eliminate exterior door access from the folding/sorting room. This will be completed by 3/31/3016.</p>	

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S 0912 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE</p> <p>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</p>			

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	<p>settings in which nursing care is provided in the hospital. Based on document review and interview, the nurse executive failed to ensure pain assessments and reassessments were performed according to policy and protocol for 10 of 22 closed medical records reviewed (#N1, #N4, #N5, #N6, #N10, #N11, #N13, #N14, #N15 and #N19).</p> <p>Findings include:</p> <p>1. Review of the facility policy Pain Assessment and Management Procedure, last revised 10/2012, indicated, Procedure: A. It is the responsibility of all clinical staff to assess and periodically reassess the patient for pain and relief from pain, including the intensity and quality (i.e., character, frequency, location, and duration of pain) and responses to treatment. 1. At the time of admission to the facility, the patient will be questioned regarding pain during the initial nursing assessment. ... E. The patient will undergo reassessment of pain at least once per shift and thirty (30) to sixty (60) minutes after every pain control mechanism employed by [facility]. ... G. Pain assessment interventions and evaluations will be documented electronically or on paper.</p>	S 0912	<p>Responsible Persons: Director of Inpatient Units and Director of Emergency Department. The Director of the Inpatient Units and Director of the Emergency Department will develop a monitoring audit tool and define an chart auditing process to ensure pain assessments and reassessments are completed. This process includes identification of individuals who will participate as auditors. This will be completed by 12/31/2015. After training on the audit reporting tool, the auditors will conduct a review of charts using sampling methodology. Any chart found to have deficiencies will be reported to the Department Director. The Department Director will provide one-on-one feedback to the individual nurse and monitor for trends. This process will be implemented by 01/31/2016.</p>	01/31/2016	

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	<p>2. Review of the facility policy Pain Assessment in Children Procedure, last revised 01/2014, indicated, I. Procedure: A. Pain is assessed to understand how much pain a child is experiencing and to understand if what is being done to relieve the pain is working (pain scale examples attached). ... III. Numerical Pain Scale: A. Children 5 to 10 years of age and adolescents. 1. 0- 10 zero equals no pain, 10 equals worst possible pain. IV. Pain Affect Faces Scale: A. Children 5 to 10 years of age and adolescents. 1. Children are presented with face drawings representing the happiest feeling possible to the saddest feeling possible. The faces are assigned numbers for quantifying children's responses.</p> <p>3. Review of medical record #N1, a 61-year old admitted 06/07/15, indicated intravenous (IV) pain medication was administered at 2139 hours on 06/07/15 for a pain score of 7, but the record lacked documentation of a reassessment. The patient also received IV medication at 0101 hours on 06/08/15 for a pain score of 8, but the record lacked documentation of a reassessment.</p> <p>4. Review of medical record #N4, a 42-year old admitted 08/19/15, indicated IV pain medication was administered at</p>			

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	<p>0826 hours on 08/19/15 for a pain score of 6, but the reassessment was not documented until 1015 hours with no pain score identified.</p> <p>5. Review of medical record #N5, a 62-year old admitted 06/07/15, indicated oral pain medication was administered at 2020 hours on 06/09/15 for a pain score of 9, but the reassessment was not documented until 0111 hours on 06/10/15 with no pain score identified, just the word "yes".</p> <p>6. Review of medical record #N6, a 72-year old admitted 06/08/15, indicated IV pain medication was administered at 1704 hours on 06/10/15 for a pain score of 8, but the record lacked documentation of a reassessment. The patient also received IV medication at 2225 hours on 06/10/15 for a pain score of 8, but the reassessment was not documented until 0045 hours on 06/11/15.</p> <p>7. Review of medical record #N10, an 89-year old admitted 06/15/15, indicated a pain score of 10 upon admission at 0522 hours. Documentation indicated IV medication was administered at 0652 hours and 0806 hours, but the record lacked documentation of further comments or pain scores.</p>			

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	<p>8. Review of medical record #N11, a 5-year old who presented to the Emergency Department (ED) at 1905 hours on 07/25/15, with complaints of headaches, indicated a pain assessment at 1926 hours which indicated "faces" as the scale used for the pain assessment, but no score or other comments were documented. The patient received oral medications for pain and nausea at 1944 hours, but the record lacked any further documentation of reassessments.</p> <p>9. Review of medical record #N13, a 10-year old who presented to the ED at 1852 hours on 08/26/15, with complaints of arm pain after a fall, indicated a pain score of 10 at 1901 hours with oral medication administered at 1927 hours. At 2016 hours, documentation indicated the patient was still having pain, but no score was documented. Documentation indicated the physician was notified and additional medication was given at 2019 hours with no further pain documentation prior to discharge from the ED.</p> <p>10. Review of medical record #N14, a 12-year old who presented to the ED at 1554 hours on 06/23/15, with complaints of ankle pain, indicated a pain assessment at 1600 hours which indicated "faces" as the scale used for the pain assessment, but no score or other comments were</p>			

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	<p>documented.</p> <p>11. Review of medical record #N15, a 14-year old who presented to the ED at 1514 hours on 08/08/15, with complaints of a rash, indicated a pain assessment at 1536 hours of acute pain in the arm with a score of 6. The record lacked any further pain documentation or pain interventions prior to discharge from the ED.</p> <p>12. Review of medical record #N19, a 40-year old admitted 07/28/15, indicated oral pain medication was administered at 1520 hours on 07/28/15 for a pain score of 6, but a reassessment was not documented until 2018 hours on 07/28/15. The patient also received IV medication at 2330 hours on 07/28/15 for a pain score of 5, but the reassessment was not documented until 0149 hours on 07/29/15.</p> <p>13. In interview at 11:50 AM on 10/28/15, staff member #A5, the Director of Quality Assessment and Performance Improvement, confirmed the issues with pain assessments and reassessments in the medical records and no further documentation was provided prior to exit.</p>			

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S 0952 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on document review and staff interview, the facility failed to follow an approved medical staff policy/procedure for 2 of 7 transfusions reviewed, T#3 and T#4.</p> <p>Findings include:</p> <p>1. Review of a policy/procedure titled: "Blood Transfusion Procedure, Procedure Number: Nursing Clinical 5335, effective 20/01/13," revealed: "PROCEDURE: G. The patient's temperature, pulse, respiration (TPR) and blood pressure (BP) are taken prior to blood administration and recorded on the Transfusion Record. I. 8. Vital signs will be taken and recorded on the Transfusion record after the first fifteen (15) minutes and at the completion of the blood transfusion." 2. Transfusion record review on 10/27/15 revealed:</p>	S 0952	<p>Responsible Persons: Director of Inpatient Units, Director of Emergency Department and Director of Laboratory. The Director of the Inpatient Units and Director of the Emergency Department will develop a monitoring audit tool and define an chart auditing process to ensure blood transfusion documentation (including vital signs) are completed for each unit of blood administered. This process includes identification of individuals who will participate as auditors. This will be completed by 12/31/2015. Laboratory auditors will review documentation for blood transfusions as a double check. Any noncompliance event will be tracked via the adverse event reporting system. Department Directors will conduct one-on-one educational efforts with staff as needed. This process will be implemented by 1/31/2016.</p>	01/31/2016	

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S 1118 Bldg. 00	<p>a. T#3 was started at 1553 and the 15 minute vitals were taken at 1555. Policy/procedure not met.</p> <p>b. T#4 was started at 0915 and the pre vitals were taken at 0915. Policy/procedure not met.</p> <p>3. In interview on 10/27/15 at 12:20 p.m., staff person p18 confirmed the above records.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on documentation review, observation, and interview, the hospital failed to conduct weekly inspections of the Emergency Department's decontamination shower.</p> <p>Findings included:</p> <p>1. In review of the Emergency Eye Wash Station/Showers Procedure policy (last</p>	S 1118	Responsible Person: Manager of Physical Engineering Weekly preventative maintenance work sheets were initiated 12/1/2015. Documentation is completed on a tag at the decontamination shower. These were initiated 12/1/2015. Supporting documentation is attached for review.	12/01/2015

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	<p>revised 2/5/201`5) indicated Engineering will provide and install inspection tags where the weekly inspection dates are to be recorded on each eye wash station and shower.</p> <p>2. During the tour of the Emergency Department at 9:30 AM on 10/27/2015, the decontamination shower was observed without an inspection tag on it.</p> <p>3. In interview of staff member #17 (Emergency Department Director) at 9:45 AM on 10/27/2015, the staff member indicated the decontamination shower was not inspected by the Emergency Department's staff members.</p>			