

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/16/2012	
NAME OF PROVIDER OR SUPPLIER  FRANCISCAN ST FRANCIS HEALTH - CARMEL				STREET ADDRESS, CITY, STATE, ZIP CODE 12188 B NORTH MERIDIAN STREET CARMEL, IN 46032			
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S0000	<p>This visit was for an initial licensure survey.</p> <p>Facility Number: 012826</p> <p>Survey Date: 10-15/17-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 11/02/12</p>	S0000					

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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S0318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice for 6 of 10 medical staff credential files reviewed.</p> <p>Findings:</p> <p><u>1. Review of facility Policy No. 950.81 , entitled CARDIOPULMONARY RESUSCITATION (CPR), BASIC LIFE SUPPORT (BLS), ADVANCED CARDIAC LIFE SUPPORT (ACLS) AND PEDIATRIC ADVANCED LIFE SUPPORT (PALS) COMPETENCY FOR THE MEDICAL STAFF, approved</u></p>	S0318	<p>The Medical Staff Department initiated a revision to the Medical Staff Cardiopulmonary Resuscitation policy (CPR) by discussing the content with physicians involved with specific specialty areas who would potentially respond to emergent and urgent situations. (A copy of the proposed draft revised policy is attached – Medical Staff Policy Cardiopulmonary Resuscitation.) The credentialing process for appointment and reappointment will include maintenance of current certifications for CPR/BLS, ACLS, or PALS. This certification will be a component of the credentialing process.</p> <p>The Medical Staff Executive</p>	11/27/2012			

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	<p>February 24, 2012, indicated those medical staff members who were required to have BLS, ACLS and PALS. However, the policy did not state for any other members of the medical staff what constituted competency for them.</p> <p>2. Review of 10 medical staff credential files indicated files MD#4, MD#5, MD#6, MD#7, MD#9, and MD#10 did not have any documentation of CPR competency (BLS, ACLS or PALS). There also was no documentation of what constituted competency for them.</p> <p>3. In interview, on 10-16-12 at 10:15 am, employee #A1 hospital staff verified the files contained no documentation of what constituted competency for the above medical staff members and no other documentation was provided prior to exit.</p>		<p>Committee of Franciscan St. Francis Health – Carmel will review and address the content of a revised Cardiopulmonary Resuscitation Policy (CPR) at their regularly scheduled meeting on Tuesday, November 20, 2012. The Medical Staff Department Coordinator and Manager will ensure that the Medical Executive Committee addresses and takes action on the proposed policy.</p> <p>The expected approval date of this proposed revised policy will be at the time that the Central Indiana Region Board of Directors takes action to approve the policy at their regularly scheduled meeting on Tuesday, November 27, 2012.</p> <p>Responsible Persons: Medical Staff Department Coordinator and Manager and Medical Executive Committee</p> <p>Date of Completion: November 20, 2012 – Medical Executive Committee, and November 27, 2012 – Central Indiana Region Board of Directors</p>		

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S0674	<p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(f)</p> <p>(f) If sufficient or suitable outside facilities are not provided by undertakers or others, the hospital shall have a morgue or a low temperature body holding room. Policies covering appropriate refrigeration requirements and length of holding bodies shall be approved by the medical staff. If autopsies are performed in the hospital, there shall be a refrigerated storage unit designed for holding bodies, along with hand washing facilities and other necessary personal hygiene facilities available.</p> <p>Based on document review and interview, the hospital failed to have a policy approved by the medical staff related to appropriate refrigeration requirements and length of time for holding a body in the absence of a facility morgue.</p> <p>Findings:</p> <p>1. Facility policy " Care of the patient after death " , last reviewed/revised 9-16-11, provided on page 6, # 19 " Transfer the body to the top shelf of the morgue cart and place in refrigerator " . The policy lacked a provision for holding requirements of a body in the absence of a facility morgue.</p>	S0674	<p>At the Carmel facility, the body will be placed in patient room #6 and the thermostat will be turned down to the lowest setting (65 degrees.) If there is an anticipated delay greater than four (4) hours, the body will be transported to Franciscan St. Francis Indianapolis Campus. This information has been incorporated into a policy entitled "Care of the Patient After Death" (see attached policy, page 6). This policy will be approved by the Medical Staff PI Committee at their December 17, 2012 meeting.</p> <p>Responsible Person: Director of Operations</p>	12/17/2012			

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	<p>2. During interview with S2 on 10-16-12 at 3:00 PM, S2 indicated:</p> <p>a. the facility does not have a morgue.</p> <p>b. the policy above lacked a provision for the handling of a body in relation to refrigeration requirements or length of time permitted for holding.</p>			
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S0782	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(3)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(3) Pertinent history of illness or injury, description of the illness or injury, and examination, including vital signs.</p> <p>Based on document review, observation, and interview, the facility failed to implement its medical staff rule requirement that all surgical cases must include a physical examination of the patient in 5 (4 closed medical records and 1 open medical record) of 30 medical records reviewed.</p> <p>1. Facility Medical Staff Rules, last reviewed/revised 4-12-12, provided in 7.4-1 (1) "An H&amp;P [history and physical] shall be written or dictated by the Physician prior to any surgical procedure or procedure requiring anesthesai services, ...If a patients H&amp;P is performed within 30 days prior to admission, the H&amp;P, including any changes in the patient's condition, must be updated within twenty-four(24) hours of patient admission and prior to any surgical</p>	S0782	<p>Director of Operations communicated with the physician of record on 10/20/12 regarding these deficiencies. Physician of record responded on 11/1/12 stating that the oversight had been rectified.</p> <p>Pre/Post staff will verify that H&amp;P on all patients is no more than thirty days old and that it is updated the day of surgery.</p> <p>Director of Operations will communicate this to all clinical staff. The Pre/Post and O.R. team leaders will be responsible for ongoing oversight for H&amp;P compliance.</p> <p>(See attached email to physician of record dated 10/20/12 as well as response from physician of record dated 11/1/12.)</p> <p>Responsible Person: Pre/Post and O.R. Team Leaders</p>	11/01/2012			

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	<p>procedure or any procedure requiring anesthesia...." (2) iv. Components of an H&amp;P include: Eyes; Ear, Nose and Throat; Heart; Lungs; Abdomen; Genito-Urinary; Musculoskeletal; Skin; Neurologic; Inventory of Body Systems. (b) Focused History and Physical Examination 1) May be used only for outpatient procedures not requiring general anesthesia or moderate or deep sedation....3) Must include...vi. Focused physical examination".</p> <p>2. During review of medical records with S3 on 10-15 and 10-16-12 the following was noted:</p> <p>a. N6 had a surgical procedure on 8-16-12 under conscious sedation.</p> <p>i. The H &amp; P in the medical record was signed by M1 on 8-16-12.</p> <p>ii. The section of the history and physical form included an area: "Significant Physical Findings: 1.Head, Ears, Eyes, Nose, and Throat 2.Neck 3.Chest 4.Breast 5.Heart 6.Abdomen 7.Extremities 8.Neurological and Additional Notes " .</p> <p>iii. Written on the side of this area</p>			

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	<p>" WNL per pt. LB " . The areas beside all of the above 8 areas were blank apart from the notation above.</p> <p>b. N8 had a surgical procedure on 8-2-12 with Monitored Anesthesia Care.</p> <p>i. The H &amp; P in the medical record was dated 7-31-12 and updated and signed by M1 on 8-2-12.</p> <p>ii. The section of the history and physical form included an area: "Significant Physical Findings: 1. Head, Ears, Eyes, Nose, and Throat 2.Neck 3.Chest 4.Breast 5.Heart 6.Abdomen 7.Extremities 8.Neurological and Additional Notes " .</p> <p>iii. Written on the side of this area " WNL per pt. LB " . The areas beside all of the above 8 areas was blank apart from the notation above.</p> <p>c. N28 had a surgical procedure on 8-6-12 with Monitored Anesthesia Care.</p> <p>i. The H &amp; P in the medical record was dated 8-6-12 and signed by M1</p>			

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	<p>on 8-6-12.</p> <p>ii. The section of the history and physical form included an area: "Significant Physical Findings: 1.Head, Ears, Eyes, Nose, and Throat 2.Neck 3.Chest 4.Breast 5.Heart 6.Abdomen 7.Extremities 8.Neurological and Additional Notes " .</p> <p>iii. Written on the side of this area " WNL per pt. LB " . The areas beside all of the above 8 areas was blank apart from the notation above.</p> <p>d. N29 had a surgical procedure on 7-23-12 with Monitored Anesthesia Care.</p> <p>i. The H &amp; P in the medical record dated 7-11-12 updated and signed by M1 on 7-23-12.</p> <p>ii. The section of the history and physical form included an area: "Significant Physical Findings: 1.Head, Ears, Eyes, Nose, and Throat 2.Neck 3.Chest 4.Breast 5.Heart 6.Abdomen 7.Extremities 8.Neurological and Additional Notes " .</p> <p>iii. Written on the side of this area</p>						

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	<p>" WNL per pt. LB " . The areas beside all of the above 8 areas was blank apart from the notation above.</p> <p>e. N30 was an open medical record review of a patient having a surgical procedure on 10-16-12 with Monitored Anesthesia Care.</p> <p>i. The H &amp; P in the medical record dated 10-9-12 and updated and signed by M1 on 10-16-12.</p> <p>ii. The section of the history and physical form included an area: "Significant Physical Findings: 1.Head, Ears, Eyes, Nose, and Throat 2.Neck 3.Chest 4.Breast 5.Heart 6.Abdomen 7.Extremities 8.Neurological and Additional Notes " .</p> <p>iii. Written on the side of this area " WNL per pt. history. LB " . The areas beside all of the above 8 areas was blank apart from the notation above.</p> <p>3. While on tour of the facility, and in the presence of S3, on 10-16-12 at 12:45 PM to 1:00 PM in the pre-operative area, N30 was in room</p>						

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	<p>7 and ready to be transported to the surgical suite once M1 had examined N30. M1 arrived at 12:50 PM, reviewed N30's chart, and went to room 7 and spoke to N30 and N30 ' s family. No physical examination was performed and N30 was transported to the surgical suite at 12:55 PM.</p> <p>4. During interview with S1 on 10-16-12 at 3:30 PM, S1:</p> <p>a. verified the findings in the medical records and that the above-referenced H&amp;Ps were the only H&amp;Ps in the medical record written or dictated by the surgeon prior to the surgical procedures for N6, N8, N28, N29, and N30.</p> <p>b. indicated that the notations in the history and physical that systems were "WNL per pt. LB" meant that systems were "within normal limits per patient " and that LB was the initials of the surgeon.</p> <p>c. indicated the above notations in the History and Physicals of N6, N8, N28, N29, and N30 under " Significant Physical Findings " did not satisfy the medical staff rules and</p>			

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	facility expectation for history and physical examination of a surgical patient.						

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S1028	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent.</p> <p>Based on document review and interview, the hospital failed to have 3 policies regarding security of and authorized access to all drug storage areas approved by the medical staff, when the pharmacist is absent.</p> <p>Findings:</p> <p>1. Review of the following documents, regarding security of and authorized access to all drug storage areas, indicated they were not approved by the medical staff:</p> <p>POLICY NO: 111.E.4, ENTITLED PYXIS MEDSTATION SYSTEM, approved by the facility February 24, 2012.</p> <p>POLICY NO: I.C., entitled ACCESS TO</p>	S1028	<p>Pharmacy staff reviewed all policies to determine which policies had NOT been approved by Pharmacy and Therapeutics Committee that contained aspects concerning medication access and storage. It was determined that the following policies needed to be reviewed by the P&amp;T Committee:</p> <p>Pyxis Medstation System Access to Pharmacy III.J.3 – Borrow/Loan Process for Emergency Procurement III.E.10 – C-II Medication Ordering Process 300.6 - Pyxis Override II.B.2 - Self Administration of Medications I.D - Staffing Requirements III.K.5 - Transferring Meds Between Campuses I.B.a - Hours of Pharmacy Service</p>	11/20/2012			

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	<p>PHARMACY, revised by the facility April 4, 2012. POLICY NO. I.Z., entitled MEDICATION STORAGE, approved by the facility February 24, 2012.</p> <p>2. In interview, on 10-17-12 at 9:30 am, employee #A7 verified the policies were not approved by the medical staff and no further documentation was provided by exit.</p>		<p>200.2 - Medications Management</p> <p>These policies were reviewed and subsequently approved at the Pharmacy and Therapeutics Committee meeting on November 6, 2012 (see attached P&amp;T Committee minutes). The "Medication Storage" policy is undergoing some further modifications and will be submitted for approval at the December Pharmacy and Therapeutics Committee meeting on December 4, 2012. The minutes from this meeting will be reviewed for approval at the Franciscan St Francis Carmel Medical Executive Committee Meeting on November 20, 2012. (The "Medication Storage" policy will be reviewed at the December MEC meeting). The approval by the Medical Executive Committee will meet the requirement of physician approval, and will be reflected in MEC minutes, which are then sent to the hospital board for final review.</p> <p>All policies subsequent policies concerning medication access and security will be sent to Pharmacy and Therapeutics Committee for approval, and will follow this same pathway for subsequent Medical Staff approval. (See attached minutes from the November 6, 2012 Pharmacy and Therapeutics Committee meeting.)</p>				

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			<p>Responsible Person: Pharmacy Coordinator from Franciscan St. Francis Healthcare Carmel Hospital</p> <p>Date of Completion: November 6, 2012 P&amp;T Committee Approval, and November 20, 2012 Carmel Medical Executive Committee Approval</p>	

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NAME OF PROVIDER OR SUPPLIER  FRANCISCAN ST FRANCIS HEALTH - CARMEL				STREET ADDRESS, CITY, STATE, ZIP CODE 12188 B NORTH MERIDIAN STREET CARMEL, IN 46032			
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S1124	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.</p> <p>Based on document review and interview, the facility failed to follow its schedule to inspect and maintain 6 pieces of equipment.</p> <p>Findings:</p> <p>1. Review of a document entitled CARMEL - HOSPITAL - HVAC EQUIPMENT, indicated Items F-2, F-2, F-4A, F-4B, F-4C AND F-4D, all exhaust fans, had a PM (preventive maintenance) frequency of SA (semi-annual).</p> <p>2. On 10-15-12 at 11:30 am, employee</p>	S1124	<p>Periodic inspection, preventive maintenance and repair of the physical plant and equipment is scheduled and performed by Engineering Department personnel and is documented by means of a computerized maintenance management program. As shown on attached Work Order Report, exhaust fans EF-1, EF-2, EF3, EF-4A, EF-4B, EF-4C and EF-4D, and EF-5 are now scheduled for preventive maintenance twice a year during the months of April and October. It is the responsibility of the Franciscan St. Francis Health Manager of Facilities and Plant</p>	11/30/2012			

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	#A8 was requested to provide documentation of PM of the above items.  3. In interview, on 10-16-12 at 9:30 a, employee #A8 indicated the PM had not been performed since the facility opened in April, 2012. No further documentation was provided prior to exit.		Operations to ensure that the preventive maintenance is planned and scheduled for the physical plant and equipment at the Carmel Hospital. (See attached work order #0000219474 and PM451-07.) To get this on the April and October schedule, a work order has been submitted and this preventive maintenance occurred on November 19, 2012. (See attached work order that is signed indicating the completion date of this preventive maintenance on November 19, 2012.)  Responsible Person: Manager of Facilities and Plant Operations				

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S1186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy.</p> <p>Findings:</p> <p>1. Review of a document entitled CARMEL CAMPUS MANAGEMENT PLAN FOR LIFE SAFETY and FIRE CONTROL - 2012, approved 4-21-12, in section V., entitled STANDARDS OF PERFORMANCE AND INFORMATION GATHERING AND</p>	S1186	The Carmel Campus Management Plan for Life Safety and Fire Control indicated that employee knowledge of the "RACE" Fire Plan is verified during monthly fire drills. This statement is in error as drills are conducted once per shift per quarter at the Carmel Campus in accordance with the NFPA Life Safety Code. As shown on the attached Carmel Campus Management Plan for Life Safety and Fire Control, the plan has been changed to reflect the actual fire drill frequency for the Carmel	11/14/2012			

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	<p>REPORTING, indicated the employee knowledge of the "RACE" Fire Plan is verified during monthly fire drills</p> <p>2. Review of fire drills conducted at the facility between April 2012 and September 2012, indicated there were no fire drill conducted in May, June and September.</p> <p>3. In interview, at 4:30 pm on 10-16-12, employee #A8 indicated fire drills were not conducted monthly and no further documentation was provided prior to exit.</p>		<p>Campus which is quarterly. All the management plans that concern the environment of care have been reviewed to ensure they reflect the policies and procedures that are in place at the Carmel Campus. In addition all plans are reviewed annually to incorporate new requirements and changes to existing procedures. It is the responsibility of the Director of Safety and Security to ensure that the management plans are reviewed annually. (See attached Management Plan for Life Safety and Fire Control – 2012.)</p> <p>Responsible Person: Director of Safety and Security</p>		

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S1204	<p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(a)(1)(A)(B)(C)(D) (E)(F)</p> <p>(a) The hospital shall have on-site, or available by arrangement, the diagnostic imaging services required by the needs of the patients served and within the scope of the service provided, that are in compliance with federal and state rules, as follows:</p> <p>(1) If radiation emitting or nonionizing services, either diagnostic or therapeutic, are provided, the applicable requirements of this section apply. The services may include, but not be limited to the following:</p> <p>(A) Mammography. (B) Computerized tomography. (C) Magnetic resonance imaging. (D) Ultrasound. (E) Catheterization lab. (F) Interventional radiology.</p> <p>Based on document review and interview, it could not be determined if personnel were properly operating radiological equipment because the facility failed to have written policies and procedures on the use of all radiological equipment.</p> <p>Findings:</p> <p>1. On 10-15-12 at 11:30 am, employee</p>	S1204	<p>The Imaging Services policy and procedure, "Personnel Requirements" (see attached) was revised to include the information regarding who is qualified to operate the equipment and how the equipment will be operated.</p> <p>Responsible Person: Manager of Imaging Services</p>	10/22/2012			

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	<p>#A1 was requested to provide documentation of all policies and procedures for the entire department, including mammography, computed tomography, magnetic resonance imaging and ultrasound.</p> <p>2. Review of the policies and procedures indicated there were none pertaining to the correct operation of any of the above-stated equipment.</p> <p>3. In interview, on 10-17-12 at 10:35 am, employee #A12 indicated there was no documentation of the policies and procedures pertaining to the correct operation of any of the above-stated equipment. No other documentation was provided prior to exit.</p>						