

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150082	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/15/2015
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NAME OF PROVIDER OR SUPPLIER DEACONESS HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN 47747
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S 0000 Bldg. 00	<p>This visit was for the investigation of 2 State hospital complaints.</p> <p>Complaint #IN00175146 Substantiated; No deficiencies related to the allegations are cited. A deficiency unrelated to the allegation is cited.</p> <p>Complaint #IN00179565 Substantiated; State deficiencies cited.</p> <p>Facility #: 005074</p> <p>Dates of Survey: 10/14-15/15</p> <p>QA: cjl 11/30/15</p>	S 0000		
S 0508 Bldg. 00	<p>410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1(b)(1)(A)(B)</p> <p>(b) The food and dietetic service shall have the following:</p> <p>(1) A full-time employee who: (A) serves as director of the food and dietetic services; and (B) is responsible for the daily management of the dietary services.</p> <p>Based on document review, observation and interview, the director of food services failed to ensure food</p>	S 0508	Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies:	12/21/2015

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>management policy and procedure (P&P) was followed for 2 foods served for a patient meal (vegetables and rice).</p> <p>Findings:</p> <p>1. Review of the P&P titled Temperature Control for Production/Serving Area indicated the following: Hot Foods; Temperature Range: Within 2 hours: from 135 degrees Fahrenheit to 70 degrees Fahrenheit. Prior to taking food to the patient tray line and/or cafeteria - check temperatures of food. Follow guidelines. (See Attachment #1). The document "Temperatures of Tray Line Food" indicated Acceptable Temperatures as follows: Veggies - 135 degrees Fahrenheit or greater; Hot Cereal - 170 degrees Fahrenheit. The P&P was revised January 2014.</p> <p>2. On 10/15/15 at 11:23am, during tour of the South unit, in the presence of C3, Registered Nurse Team Leader, C6, Dietary Team Leader, tested the temperatures of the foods on a random patient tray. Temperatures of the foods were tested at 11:26am, the time patients received their trays, and documented as follows: mixed vegetables 127 degrees Fahrenheit, rice 128 degrees Fahrenheit.</p> <p>3. On 10/15/15 at 11:26am, C6 verified</p>		<p>Responsible Parties for columns 2 and 3: Target Date: Give specific dates: 0508: Dietetic Services: Director of food services failed to ensure food management policy and procedure was followed for 2 foods served for a patient meal. (Cross Pointe facility) 1. The type of food containers has been changed to maintain the temperature of served food items. 2. Educate Dietetics staff on SOP (Standard Operating Procedure): dishing up hot food for patient trays no earlier than 5 minutes prior to delivery to nursing unit (Exhibit A). Temperatures continue to be taken prior to dishing up food for patient trays. (Exhibit B) 3. Inform nursing staff the patient trays have arrived on unit. 4. Educate nursing staff on the importance of serving patient trays as soon as possible. 1. Compliance with SOP included with Test Tray daily. 2. Compliance included in the Daily Statement Fact Log—QA program (Exhibit C). Test Trays meet policy standards, "Temperature Control for Production/Serving Area". 1-3. CP Dietary Team Leader and Operation Manager at Gateway Dietetics Dept. 4. DCP Nurse Manager All steps to be completed 12/21/2015.</p>	

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S 1164 Bldg. 00	<p>the temperatures of the food on the test tray.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the hospital failed to ensure evidence of preventive maintenance (PM) according to facility policy and procedure (P&P) for testing of hot water temperatures in patient areas throughout the hospital.</p> <p>Findings:</p> <p>1. Review of the P&P titled Hot Water Temperature Monitoring indicated the following: Each month a PM work order will be issued to the Coordinator to conduct the testing of hot water temperatures in patient areas throughout</p>	S 1164	<p>Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies: Responsible Parties for columns 2 and 3: Target Date: Give specific dates: 1164: Policy Titled Hot Water Temperature Monitoring indicated monthly PM testing of the Hot Water when the testing is only done annually.</p> <p>The policy was updated 10/16/2015 to reflect actual procedure of annual testing of the hot water at Cross Pointe. Updated Policy Manager Engineering and Maintenance: This is a departmental policy and as such doesn't require review</p>	10/16/2015

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S 1510 Bldg. 00	<p>the Hospital. The coordinator will assign the testing to qualified personnel and issue a form for recording temperature readings...the completed form, along with the signed PM work order will be returned and results entered into the preventive maintenance system. The P&P was effective February 2014.</p> <p>2. Review of 2015 PM documentation of temperature recordings in patient care areas of the facility lacked documentation of monthly testing/recorded temperatures.</p> <p>3. On 10/15/15 at 12:55pm, C2, Administrative Assistant, indicated the main campus of the hospital does the monthly water temperature checks as described in the P&P, but this campus, having fewer rooms, does not. C2 indicated the P&P has been changed today to more reflect the procedure being done. C2 indicated the P&P had not yet been approved by the safety committee or the governing board.</p> <p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the</p>		<p>other than that of the Manager of Engineering and Maintenance. Per Health System Policy 10-01S, <i>Development and Maintenance of Deaconess Health System and Deaconess Hospital Policies and Procedures, Section IV C.4:</i> It is the responsibility of Department Directors/Managers to review and update their departmental policies in the timeframes specified in Policy 10-01S. 10/16/2015</p>				

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	<p>emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following:</p> <p>(A) Provision for the care of the disturbed patient.</p> <p>(B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care.</p> <p>(C) Provision for transfer of patients when care is needed which cannot be provided.</p> <p>Based on document review and interview, the hospital failed to follow written policy and procedure (P&P) regarding the care of the disturbed patient for 1 of 5 emergency department patients (Pt#1).</p> <p>Findings:</p> <p>1. Review of the P&P titled Suicide Risk Assessment and use of the Safe Rooms at Gateway ED (Emergency Department) indicated the following: Any Emergency Department patient tat arrives with a chief complaint related to mental health/psychiatric or substance abuse will have a suicide/homicide risk assessment completed and appropriate precautions initiated as outlined in this policy. Suicide/Homicide Risk Assessment Questions: Are you here because you tried to hurt yourself or someone else? In</p>	S 1510	<p>Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies:</p> <p>Responsible Parties for columns 2 and 3: Target Date: Give specific dates:</p> <p>1510: Emergency Services (Provision for care of the disturbed patient) Failure to include documentation of an ED patient's contract for safety in the patient's medical record.</p> <p>ED staff will begin scanning Patient Safety ContractForms on March 1, 2016. This willrequire a build in the Onbase program into which forms are scanned toaccommodate these forms. Comply with ED policy attached: "Suicide Risk Assessment and use of the Safe Rooms at Gateway ED". ED Director and Quality Operations Supervisor to revise policy "SuicideRisk Assessment and use of the Safe Rooms at Gateway ED" to read:</p>	03/01/2016

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	<p>the past week have you had thoughts about killing yourself or someone else? If the patient answers YES to either question then Suicide/Homicide Precautions are initiated: 1. Patient is asked to sign a contract for safety (Exhibit A). The P&P was effective March 27, 2014.</p> <p>2. Review of the P&P titled Assessment and Documentation of the Emergency Department Patient indicated the following: Required documentation: Suicide/Homicide Screen: If applicable, See ED policy "Suicide Homicide Risk Assessment and Contract for Safety". The P&P was effective march 27, 2014.</p> <p>3. Review of Pt#1's medical record (MR) indicated the patient was admitted to the ED on 6/4/15 with a chief complaint of alcohol ingestion. The Suicidal Risk Assessment in the MR indicated YES, the patient had expressed suicidal ideation. The MR lacked documentation of an ED contract for safety signed by the patient.</p> <p>4. On 10/14/15 at 3:25pm, A8, Clinical Quality Supervisor, indicated Pt#1's MR indicated that a safety contract had been addressed with the patient, but lacked documentation of the signed contract.</p>		<p><i>IV. ED staff will scan the signed copy of the Contract for Safety into the EMR through Onbase. The hard copy will be stamped as scanned and sent to the Medical Records department per the pickup process.</i></p> <p>Onbase build will be done by Onbase Analyst.</p> <p>Education will be done by Medical Records Staff.</p> <p>ED employee IDs for ED employees who will perform scanning of contracts for safety will be gathered by ED Quality Operations Supervisor and given to the OnBase Analyst.</p> <p>03/01/2016: ED policy "Suicide Risk Assessment and use of the Safe Rooms at Gateway ED" to be effective.</p> <p>12/31 2015: ED Director and Quality Operations Supervisor will meet with Onbase Staff and Medical Records Manager to develop plan and timeline for implementation of scanning contracts for safety into Onbase.</p> <p>ED employee IDs to be given to Onbase Analyst by 01/18/2016.</p> <p>Onbase build for the ED scan queue will be completed by 01/31/2016.</p> <p>Education will be complete by</p>	

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			02/29/2016. EDstaff to begin scanning Patient Contract for Safety forms on 03/01/2016.		