STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151314	A. BUILDING 00 B. WING	01/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT SALEM HOSPITAL INC	911 N SHELBY ST SALEM, IN 47167

(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	This visit was for a State hospital licensure survey. Dates: 1/21/2014 through 1/22/2014 Facility Number: 005087 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Jennifer Hembree, RN PH Nurse Surveyor QA: claughlin 01/30/14	S000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 151314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT SALEM HOSPITAL INC	911 N SHELBY ST SALEM, IN 47167

(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	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (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: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and interview, the facility failed to ensure the forms utilized for blood administration and actual practice matched facility policy for one (1) blood administration policy and 1 of 6 patients receiving a blood transfusion. Findings include: 1. Facility form titled "TRANSFUSION RECORD" states "Initiate transfusion with 30 minutes of blood bank release or return product to blood bank." 2. Review of patient #5 medical record indicated the following: (A) A unit of blood was issued by the blood bank at 2116 on 12/10/13 and started at 2200 on 12/10/13. (> 30 minutes).	S000322	The blood administration policy was reviewed and revised by Edmond Jones, Manager of Laboratory Department and Mia Williams, Manager of Medical / Surgical Unit. The revised policy was submitted to Dana Muntz, Administrator / Chief Nursing Officerr and approved on February 21, 2014.The transfusion record form will be changed to eliminate the words "initiate transfusion within 30 minutes of blood bank release" to match policy.The blood administration policy will be reviewed by all nursing staff and will be included in the annual competency testing which will be held in May 2014.The Laboratory Department personnel will do ongoing monitoring and will report any discrepancies to Mia Williams, Manager of Medical / Surgical Unit	02/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167	

(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
	(B) A unit of blood was issued by the blood bank at 0032 on 12/11/13 and started at 0105 on 12/11/13 (> 30 minutes). 3. Facility policy titled "Blood Product Administration" last reviewed/revised 9/13 states on page 3 of 9: "ii. The transfusion blood/blood product must be started within one (1) hour from the time it is removed from the blood bank." 4. Staff member #N11 verified the above at 3:00 p.m. on 1/22/14.			
S000554	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, the facility failed to provide equipment that could be appropriately disinfected between patients for 1 surgical area toured. Findings include: 1. During tour of the surgery department beginning at 10:45 a.m. on 1/22/14 and accompanied by staff	S000554	Kevin Lyles and Brittney Garloch, Supervisors of the Surgery Department, immediatley removed the wedge pillow from the Surgery Department on the day of the ISDH survey, February 21, 2014. The Supervisors of the Surgery Departmetn have worked with Terry Wheeler, the Team Lead of Supply Chain, and ordered two new wedge pillows. The pillows will be monitored on a	02/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT SALEM HOSPITAL INC	911 N SHELBY ST SALEM, IN 47167

(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
	members #N11 and N13, a wedge cushion utilized in the procedure room for patient positioning was observed to have numerous tears and wear of the vinyl cover. The cushion had numerous pieces of tape covering some of the torn areas making it impossible to appropriately disinfect the cushion between patients.		monthly basis for tears to insure a safe and healthful environment.The pillows are wiped down with hospital-approved disinfectant wipes in between patient use as per our infection control policies.	
S001028	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (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. Based on observation and staff interview, the facility failed to ensure medications were secure in 1 emergency department (ED) trauma room. Findings include: 1. During tour of the ED beginning at	S001028	The lock on the Emergency Department was replaced immediately on the day of the ISDH survey The "Pharmacy Medication Storage Area Inspection" policy will be enforced and inspection sheets will be turned in to Jim Passereni, Manager of the Pharmacy Department on a monthly	01/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167	

(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
	11:35 a.m. on 1/22/14 and accompanied by staff members #N11 and N12, an unlocked cabinet was located in trauma room 1 which contained medications including, but not limited to, Epinephrine, Lidocaine, and Nitropress. 2. Staff member #N12 indicated the following in interview during the tour: (A) The trauma room is utilized for regular ED visits as well as trauma. (B) The cabinet has a magnetic lock which must be broken.		basis. Any deficiencies will be reported to the Quality Committee and to the Pharmacy and Therapeutic Committee.New Pxysis equipment has been installed in the Emergency Department which will alleviate the need to store drugs in a locked cabinet in the Emergency Department.	
S001118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation and documentation review, the facility failed to maintain the hospital's equipment in such a manner that the safety and well-being of	S001118	Venon Fleming, Manager of Plant Operations, submitted a purchase order to replace the bench grinder. The bench grinder located in the Plant Operations Department has been replaced with a new grinder which includes	02/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167	

(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
	patients, visitors, and/or staff are assured in two (2) instances in the Maintenance Department. Findings included: 1. Safety Management Plan Life Safety Code Occupancy: Health Care (last approved 1/1014) indicated the Safety Management Plan of the facility serves to provide a framework to promote a safe environment for patients, visitors, and staff, The plan requires the facility staff to adhere to the Life Safety Code and OSHA requirements and regulations. 2. OSHA standard, 29 CFRb1915.134 indicates floor stand and bench mounted abrasive wheels used for external grinding shall be provided with safety guards (protection hoods). 3. At 12:10 PM on 1/22/2014, the Maintenance Department was toured. The table top bench grinder with 2 wheels was		safety guards. The yellow "Flammable" cabinet was removed of debris adn painted.A daily tour of the department by Venon Fleming, Manager of Plant Operations, will be conducted in the future. Any deficiencies in the department will immediately be reported to the Safety Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167	

(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
	observed with no safety guards attached. 4. At 12:15 PM on 1/22/2014, the yellow 'Flammable' cabinet in the Maintenance Department was observed with assorted mixture of different stained on chemicals and loose debris on the inside shelves of the upright 'Flammable' cabinet.			
S001162	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A) (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: (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule. Based on observation, document review, and staff interview, the facility failed to comply with	S001162	On January 22, 2014, the department temperature log sheet for the Hydrocollator M-2 Master Heating Unit was modified	02/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167	

(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
	manufacturer recommendations for the Hydrocollator in the Physical Therapy Department. Findings included: 1. The Operation Manual instructions for the use and operation of the St. Vincent Salem Physical Therapy Department's Hydrocollator M-2 Master Heating Unit note the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 165 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs. 2. At 11:55 AM on 1/22/2014, the Physical Therapy Department was toured. The department had a Chattanooga Hydrocollator. The water temperature of the Hydrocollator was observed at 168 degrees Fahrenheit.		to reflect the acceptable temperature range of 160-165 degreesOn February 5, 2014, all rehab service employees were notified at a department meeting that the acceptable temperature range for this equipment is 160-165 degrees.The temperature log sheet for the Hydrocollator M-2 Master Heating Unit will be checked daily by deparment staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167	

(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
	3. The January 2014 Daily Temperature Log noted the water temperature of the Hydrocollator was 168 degrees Fahrenheit for 14 of 15 days, The log indicated the Normal range for the Hydrocollator was 160 to 170 degrees Fahrenheit. 4. At 12:00 PM on 1/22/2014, staff member #9 confirmed the Temperature Log temperature range was in conflict with the recommended Hydrocollator temperature ranges. The staff member indicated the department was exceeding 165 degrees Fahrenheit for the hot water of the M-2 Hydrocollator.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167	

(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
S001528	410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2 (b)(6) (b) The emergency service shall have the following: (6) A physician on-call roster available in the emergency service department which lists medical specialists in addition to scheduled medical staff. Based on document review and staff interview, the facility failed to maintain a medical specialists on-call list in the emergency department (ED). Findings include; 1. During tour of the ED beginning at 11:35 a.m. on 1/22/14 and accompanied by staff members #N11 and N12, the following was observed: (A) The binder for on-call physicians lacked a specialist on-call list. 2. Staff member #N12 verified at the time of the observation that there was no specialist on-call list in the binder and the section of the binder that would have the sheet was empty.	S001528	The February 2014 "Specialist Calendar" was inserted in the contact book in the Emergency Department immediately on the day of the the ISDH inspection.Melissa Richardson, Manager of Marketing and Public Relations, is responsible for maintaining a current calendar of on-call specialist doctors in the clinicaldepartments. The Emergency Department night shift personnel will be responsible for ensuring the calendars are kept up-to-date in the Emergency Department. Random checks will be conducted in clinical departments to ensure the calendars are readily available and up-to-date. Any deficiencies will be reported to Administration.	01/22/2014