

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 01/04/2012
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NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 005087</p> <p>Survey Dates: 01-03/04-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratorian</p> <p>QA: claughlin 01/25/12</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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S0102	<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 document review and staff interview, the facility failed to comply with all applicable state laws for 1 of 1 unlicensed nursing assistant employee files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. 2. Review of staff member #N3 personnel file indicated that he/she was hired on 10/3/11 as a nursing assistant. The file lacked documentation of a nurse aide registry report. 3. Staff member #11 indicated in 	S0102	<p>Who: Val Potter, Manager Human Resources and Risk, will be responsible for checking the nurse aide registry report prior to start date. What: Val will apply within three businessdays from the date the associate is employed for a copy of the IN nurse aide registry report and a criminal history. When: Val has initiated this practice immediately with all new hires. She was currently running the criminal history and only checking the registry for the certified nurse aide. How: Val has added this practice to her new hire check list. This will be monitored with her HR quality monitors and sent through the QA committee quarterly up to the Board of Directors for review.</p>	01/06/2012			

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	interview at 2:00 p.m on 1/4/12 that he/she did not check the registry for nonlicensed nursing assistants.				

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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.</p> <p>Based on document review, the facility failed to ensure the Chief Nursing Officer (CNO) maintained a current CPR certification.</p> <p>Findings include:</p> <p>1. Review of staff member #8 (CNO) personnel file indicated the following: (A) His/her CPR expired 9/09. (B) A letter written by staff member #N1 indicated that staff member #8 had passed the skills check off and written exam for CPR recertification on 1/4/12.</p> <p>2. Staff member #N1 indicated the following in interview at 2:25 p.m. on 1/4/12: (A) He/she verified that staff member #8</p>	S0318	<p>Who: Staff Development, Department Managers, and Associates are responsible for monitoring expiration dates of associates certifications. What: A spreadsheet is kept on the common drive that has certification/training dates and expiration date. CNO will be moved from administration to clinical to allow for easier compliance monitoring. When: Dana passed her skills check off and written exam on 1/4/12. She does provide patient care when needed, but had not since CPR had expired. How: Spreadsheet is monitored monthly by staff development. Emails are sent to associates and their respective managers informing of their upcoming expiring certifications. CPR classes are always held on</p>	01/13/2012	

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	took written and skills test for CPR recertificaton early a.m. of 1/4/12. (B) He/she indicated that staff member #8 does provide patient care when needed.		the 1st Thursday of each month. Spreadsheet was evaluated and updated by all managers and Staff Development by 1/13/2012		

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S0320	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(G)</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: (G) Providing employee health services and a post offer physical examination, in consultation with the infection control committee.</p> <p>Based on facility document reviews and staff interview, the hospital's administration failed to document a post offer physical for one of ten personnel. Findings included: 1. The policy, "New Employee Health Evaluatins", PolicyStat ID: 50495, revised 9/09, read: "Once an assoicate is formally hired, he/she will undergo an employment health screen." 2. On 1/04/11 at 2:15 p.m., review of 1 (#6) personnel file failed to contain a post offer physical. 3. On 1/04/11 at 2:15 p.m., employee #7 acknowledged the above-listed missing</p>	S0320	Who: Val Potter, Manager Human Resources and Risk, is responsible for monitoring compliance with New Employee Health EvaluationsWhat: Val will insure that all associate will have a post-offer physical. Val contact Associate #6 and had them provide a copy of his physical on 1/6/12.When: Personnel file (#6) will have his physical completed and on file by March 16th, 2012How: Physicals are required for all associates of the hospital. This associate is a contracted associate. Copies of contracted associates physicals will be obtained and placed in their files	01/13/2012			

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S0362	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D) (E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review and interview, the facility failed to report 5 of 39 deaths as required by a facility contract and facility policy during the 3rd and 4th quarters of 2010 and the 1st and 2nd</p>	S0362	Who: Each Associate in ER is responsible for notification to IDA regarding a death in our emergency department. Betty Sease, Manager Emergency Department, is responsible for	01/06/2012			

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	<p>quarter of 2011 to the organ procurement organization (OPO).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of 2010 donation statistics for the 3rd and 4th quarter and 2011 donation statistics for the 1st and 2nd quarter of 2011 on 1-3-11 indicated the facility failed to report 5 of 39 deaths to the OPO through the IDA as required by facility contract and facility policy. Review of the facility contract with an OPO on 1-3-11 indicated the following on page 4: Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the hospital. Review of the facility policy titled ORGAN AND TISSUE PROCUREMENT on 1-3-11 indicated the following: It is the policy of this facility to refer all deaths and imminent deaths to the Indiana Donation Alliance (IDA) and to work with the donation agencies to offer the next-of-kin of every medically suitable deceased patient the opportunity to donate. Interview with B#8 on 1-3-12 at 1310 hours confirmed the hospital contract and policy require all deaths be reported to the OPO through the IDA and 5 of 39 deaths were not reported in the 3rd and 4th quarter of 2010 and the 1st and 2nd 		<p>insuring this notification is occurring. What: All deaths are to be called to the 1-800 IDA number, even Coroner cases. The 5 deaths that were not recorded where all Coroner cases. Education was sent to all ER staff via memo regarding IDA must be notified all deaths. When: This memo/notification went out on 1/5/12. Since the survey all deaths have been reported. How: This is a Quality monitor that gets reported monthly to Dana Muntz from IOPO, who then sends to QA committee quarterly and then on to the Board of Directors.</p>				

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S0566	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (e)(1)(2)</p> <p>(e) The chief executive officer, medical staff, and executive nurse shall do the following:</p> <p>(1) Be responsible for the implementation of successful corrective action plans in affected problem areas.</p> <p>(2) Provide for appropriate infection control input into plans for renovation and new construction to ensure awareness of federal, state, and local rules that affect infection control practices as well as plan for appropriate protection of patients and employees during construction or renovation.</p> <p>Based on document review and staff interview, the infection control committee failed to implement corrective action in an identified problem with handwashing compliance.</p> <p>Findings include:</p> <p>1. Review of infection control meeting minutes and quality studies related to handwashing compliance for the previous year indicated the following: (A) The facility set a threshold of 90% for handwashing compliance. (B) The last three (3) quarterly studies of handwashing compliance indicated score</p>	S0566	Who: Shelley Fultz, Infection Control, is the responsible for the monitoring and compliance tracking of handwashing. What: Handwashing compliance action plan will be developed and implemented When: Handwashing has been added to the 2/28/12 Infection Control meeting. An action plan will be developed and implemented. It will include Associate education and physician education. Education will occur in different methods: emails, fliers, associate forums, and attending unit meetings. How: Action plan and progress will be shared at IC meetings with the meeting minutes going to the QA committee quarterly up to the	01/13/2012			

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	<p>of 58%, 64%, and 68% respectively. (C) The studies and meeting minutes lacked documentation of corrective action taken related to the repeated low scores.</p> <p>2. Staff member #N1 indicated the following in interview at 2:30 p.m. on 1/4/12: (A) The department with the lowest scores was radiology. There was no documentation that the poor scores had been addressed by the department manager.</p>		Board of Directors.		

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S0570	<p>410 IAC 15-1.5-2 INFECTION CONTROL 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 document review and staff interview, the infection control committee failed to hold quarterly meetings.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of infection control meeting minutes for previous year indicated the committee failed to meet the last quarter of 2011. 2. Staff member #N1 indicated in interview at 2:15 p.m. on 1/4/12 that the 	S0570	Who: Shelley Fultz, Infection Control, is responsible for scheduling and facilitating the quarterly Infection control meetings.What: All Infection Control meetings have been scheduled for the rest of the year. Shelley contacted Dr. Irons, Medical Director of Lab, and confirmed his schedule at St. Vincent Salem on 1/20/12When: 4th Quarter 2011 meeting is on 2/28/12, 1st Quarter 2012 meeting is 4/24/12, 2nd Quarter 2012 meeting is 8/28/12, and 3rd quarter 2012 meeting is	01/20/2012			

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	last infection control meeting was held on 9/27/11 and that no meeting was scheduled at this time.		scheduled for 11/27/12.How: Each meeting goes over the privious quarter's data/statistics. Quarterly meetings will be scheduled out a year in advanced. Dates can be changed if there are scheduling conflicts with the Physician		

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S0604	<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.</p> <p>Based on record review, staff interview, the hospital failed to monitor the immune status of five of five kitchen health care workers for the diseases transmissible through food.</p> <p>Findings:</p> <p>1. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to</p>	S0604	<p>Who: Shelley Fultz, Infection Control, is responsible for the "monitoring the immune status of health care workers exposed to communicable diseases". What: New form/questionnaire was developed and signed by all current dietary staffWhen: This form will be used on all new hires to dietary department, all current associated signed form by: 1/13/12How: All new dietary associates will sign the "Dietary Employees Food Borne Disease/Illness questionnaire". This will be part of their hospital orientation.</p>	01/13/2012			

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	<p>report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of forborne disease transmission, including the date of onset of juandice or of an illness specified under subdivision (3), of the food employee or applicant:</p> <p>(1) is diagnosed with an illness due to:</p> <p>(A) Salmonella spp.;</p> <p>(B) Shigella spp.;</p> <p>(C) Shiga toxin-producing Escherichia Coli;</p> <p>(D) Hepatitis A virus; or</p> <p>(E) Norovirus "</p> <p>2. Five kitchen personnel (#'s 1 through 5) had no documentation to indicate that the above-listed history of the five food transmissible diseases had been obtained.</p> <p>3. In interview on 1/04/11 at 2:15</p>			
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	p.m., Staff member #7 acknowledged the above-listed missing documentation.				

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 01/04/2012
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S0908	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (a)(2)(A)</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: (A) licensed under IC 25-23-1-11; and</p> <p>Based on document review and staff interview, the facility failed to ensure the Chief Nursing Officer (CNO) maintained a current license.</p> <p>Findings include:</p> <p>1. Review of staff member #8 (CNO) personnel file indicated the following: (A) The job description states under education/experience requirements on page 1: "Licenses/Certification-Indiana nursing license....." (B) An Indiana online licensing form indicated his/her license expired 10/31/11. (C) A second Indiana online licensing form indicated that he/she submitted a renewal request at 6:31 p.m. on 1/3/12.</p> <p>2. Staff member #11 indicated the following in interview at 10:00 a.m. on</p>	S0908	<p>Who: CNO is responsible for monitoring her own license. Staff Development and HR are responsible for making sure licensures are current and on file.What:A spreadsheet is kept on the common drive that has certification/training dates and expiration date. CNO will be moved from administration to clinical to allow for easier compliance monitoring.When: License was renewed on 1/3/12.How: Emails are sent to Associates to remind them of license renewal, CNO will be added to the list. Spreadsheet was reviewed and updated if needed by departmental managers/staff development/HR by 1/6/12.</p>	01/06/2012	

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	1/4/12: (A) When preparing the personnel files for surveyor review on 1/3/12, it was discovered that staff member #8 did not have a valid nursing license.				

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S0952	<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).</p> <p>Based on blood transfusion policy review, transfusion document chart reviews and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for five of ten patients.</p> <p>Finding(s) include:</p> <p>1. The policy, "Administration of Blood and/or Blood Products", PolicyStat ID: 124197, approved 10/2011, read: "Obtain a signed consent for the transfusion. Using the Blood Transfusion Flow Sheet, record the number of</p>	S0952	<p>Who: Edmond Jones, Manager Lab, is responsible for monitoring compliance of the "Blood Transfusion Record".What: New Blood Transfusion record has been implemented at St. Vincent Salem. It came from MACL and our new Sunquest LIS system. This form helps facilitate compliance with our documentation deficiencies. When: Feb 1st, 2012 education started and will be completed by 3/30/12 of all associates who give blood transfusion. How:100% of all blood transfusion record will be reviewed for complianc. Department Managers will recieve a report of their respective departments documentation compliance for Blood Transfusions. This will become one of the laboratories quality monitors that are reported to the QA committee quarterly and then on to the Board of Directors.</p>	02/01/2012			

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	<p>the unit for the patient, the date of the transfusin, the unit identification (ID) number, the patient's vital signs, nursing observations and other information. Vital signs must be taken at the following times:</p> <ol style="list-style-type: none"> 1. Before the blood transfusion is started 2. Immediately after the transfusion is started 3. Every 15 minutes post start of trnasfusion X 2 4. At 30 minutes after the 2nd 15 minute check. 5. Then hourly X 4 post infusion 6. At the end of the transfusion <p>Complete all spaces on the Crossmatch/Transfusion Report"</p> <p>2. In review of five patients receiving blood units, five of these received-units did not have complete documentation, per policy, on the Blood Transfusion Flow sheet including:</p> <p>Patient #2 --Unit #1 administered on</p>			
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	<p>12/22/11 at (no start time indicated on the form):</p> <p>a. The unit was released from the blood bank at 1015.</p> <p>b. Vital signs indicated they had been taken 15 minutes before infusion occurred (1045) and vital signs were documented at 15 minutes after the start (1100).</p> <p>c. These two times failed to agree since the preinfusion vitals at 15 minutes (1045) indicated the actual infusion had occurred at 1100. This would, in turn, cause the actual 15 minutes time after the start of the unit to be 1115 and not 1100.</p> <p>Patient #4</p> <p>--Unit #1 was administered on 12/19/11 at (no start time indicated on the form); however, there was no consent available for review</p> <p>--Unit #2 administered on 12/19/11 at (no start time indicated on the form):</p> <p>a. There was no consent available for review</p>			
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	<p>b. The unit was released from the blood bank at 1405.</p> <p>c. Vital signs were documented indicating that 15 minutes after the start were at 1415</p> <p>d. These two times failed to agree since the release time (1405) was 10 minutes prior to those of the vital signs 15 minutes after the start (1415).</p> <p>Patient #6 --Unit #2 was administered on 12/12/11 at (no start time indicated on the form). The statement "Transfusion Reaction: Yes No" had not been completed.</p> <p>Patient #9 --Unit #2 was administered on 12/05/11 at (no start time indicated on the form):</p> <p>a. Vital signs had been documented for 15 minutes before the infusion at 0310. This inferred the unit was started at 0325.</p> <p>b. Vital signs had been</p>						

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	<p>documented for 15 minutes after the infusion at 0325; however, this conflicted with the inference the unit was started at 0325.</p> <p>Patient #10 --Unit #2 was administered on 12/03/11 at (no start time indicated on the form). The statement "Transfusion Reaction: Yes No" had not been completed.</p> <p>3. On 1/03/12 at 1:45 p.m., Staff member #7 acknowledged that the above-listed patient blood units had not been documented, per policy, as required.</p>				