

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151316	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2015
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NAME OF PROVIDER OR SUPPLIER  ST VINCENT FRANKFORT HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 S JACKSON ST FRANKFORT, IN 46041
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S 000  Bldg. 00	This visit was for a State hospital licensure survey.  Dates: 4/20/2015 through 4/22/2015  Facility Number: 005039  QA: cjl 05/08/15	S 000	The State Board action plan from the 4/20-4/22 survey has been attached to the appropriate measures.	
S 406  Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)  (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:  (1) All services, including services furnished by a contractor.  Based on document review and staff interview, the facility failed to ensure contracted services	S 406	1. The Quality Manager has added the following departments to our Patient Care Review Committee Scorecards (PCRC) as of May 19, 2015: Prompt	05/19/2015

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>ambulance, wound care, biohazard waste hauler, security, and in-house laundry services were part of the hospital's comprehensive Performance Improvement and Patient Safety program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The 2014 St. Vincent Frankfort Hospital Performance Improvement and Patient Safety Plan implements all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</li> <li>Review of the facility's Performance Improvement Plan and quality dashboards indicated it did not include the following contracted services: ambulance, biohazard waste hauler, wound care, security and in-house laundry services.</li> <li>At 2:05 PM on 4/21/2015, staff member #3 (Quality Manager)</li> </ol>		<p>Ambulance Service (ED), Wound Care (TXTEAM), biohazard waste hauler (Steri-cycle), Security (ED), and laundry/linen services (Touchpoint).</p> <ol style="list-style-type: none"> <li>Any future contracted services will be added to the PI project list by the Quality Manager. Annually prior to the beginning of the fiscal year, all departments/services will be evaluated to make sure they are included on the PCRC scorecard</li> <li>All departments/services PI projects will be discussed/reviewed quarterly by department managers and senior leadership.</li> <li>Audit/Completion of the PI projects for these services will begin in May 2015 and the ongoing quarterly review/discussion of these services will begin in June 2015. The Quality manager is ultimately responsible for the ensuring compliance with these PI projects.</li> </ol>	

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S 418 Bldg. 00	<p>confirmed ambulance, biohazard waste hauler, wound care, security and in-house laundry services were not part of the hospital's comprehensive Performance Improvement and Patient Safety program.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2)</p> <p>(b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action shall be documented.</p> <p>(2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.</p> <p>Based on documentation review and staff interview, the hospital failed to document action plans for</p>	S 418	<p>1. Every area of opportunity (red box) on the PCRC Scorecard will have an action item documented at the quarterly</p>	05/15/2015

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	<p>improving the quality indicators that did not meet their performance goals.</p> <p>Findings included:</p> <p>1. The 2014 St. Vincent Frankfort Hospital Performance Improvement and Patient Safety Plan indicated the Performance Improvement Committee utilizes the Performance Improvement Grid to review collection of data to process improvement; to identify, develop, implement, and measure the improvement. The Performance Improvement Committee systematic process will be utilized to analyze collected data in order to determine actions to improve the performance of processes.</p> <p>2. The 2014 St. Vincent Frankfort Hospital Performance Improvement and Patient Safety scorecards were reviewed for 2014 and 2015. Approximately 15% of the hospital's selected quality</p>		<p>meeting. An action item box has been added to the scorecards as of May 15, 2015.</p> <p>2. All department PI projects that are listed on the PCRC Scorecard will be evaluated and discussed with all department managers and senior leadership to look for areas of improvements.</p> <p>3. Quarterly meetings will be held to discuss the PCRC Scorecard and the progress on our PI projects.</p> <p>4. The Quality Manager is responsible and will help facilitate discussion at the ongoing quarterly meetings, starting on June 24, 2015. An initial action plan for all areas of improvement (red boxes) will be created. At all future meetings, all previous action plans will be evaluated to determine whether continued follow up of the item is required and to note the impact/effectiveness of the action item.</p>	

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S 596 Bldg. 00	<p>indicators did not meet their performance goals. The hospital did not provide documented evidence of action plans for improving quality indicators that did not meet their threshold.</p> <p>3. At 2:20 PM on 4/21/2015, staff member #3 (Quality Manager) confirmed the hospital did not document action plans for performance goals that did not meet their threshold.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>			

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	<p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation, and interview, the facility failed to ensure chemical Metricide high-level disinfectant was used according to the manufacturer's recommendations for the Radiology Department.</p> <p>Findings included:</p> <p>1. Metricide manufacturer sheet requires: Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water 3 times. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done.</p> <p>2. At 12:50 PM on 4/21/2015, the Ultrasound Room was toured in the Radiology Department. The room had a wall mounted vapor control system for Metricide high-level disinfectant with two separate attached canisters. One canister</p>	S 596	<p>1. The process for disinfecting the ultrasound probe in radiology has been changed as of May 15, 2015. An electronic disinfectant, (The Trophon) is on the capital list for St Vincent Frankfort.</p> <p>2. The Process for disinfecting the ultrasound probe, in radiology, will now follow the metricide manufacturer guidelines for the rinsing procedure.</p> <p>3. The new process for disinfecting will start on May 15, 2015 after education with the teach-back method has been completed with the radiology staff. Every time the u/s probe is used, the radiology tech will sign off that it was disinfected per protocol.</p> <p>4. The radiology manager is responsible for providing the education to required staff on the manual rinsing procedure for disinfecting the ultrasound probe. Monthly review of the U/S disinfection log will be completed by the radiology manger to verify whether the process is being followed every time the u/s probe is being used. This will be the interim monitoring process until the Trophon is purchased. This will be reported on the PCRC scorecard starting with the 4th quarter of FY2015. Once 6 months of 100% compliance is reached, discussion at the quarterly meeting will determine</p>	05/15/2015

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S 598	<p>was for Metricide high-level disinfectant and the other canister was for rinse water. in addition to the wall mounted vapor control system to be used for Metricide, the room had a handwashing sink.</p> <p>3. At 12:55 PM on 4/21/2015, staff member #21 (Radiology Technician) indicated the canister of water that is part of the wall mounted vapor control system was for the medical device (ultrasound probe) to submerge into the canister of water. This process then was followed by holding the probe under running water from the faucet of the handwashing sink. Then the probe will be wiped dry with a paper towel. This process does not meet the rinsing requirements for thoroughly rinsing off the Metricide excess from the ultrasound probes.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL</p>		whether this item needs to continue to be measured.				

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Bldg. 00	<p>410 IAC 15-1.5-2(f)(3)(D)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on observation and staff interview, the facility failed to ensure the Radiology Department was complying with FDA (Food and Drug Administration) requirements on not refilling Ultrasound Gel containers.</p> <p>Findings included:</p> <p>1. FDA indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. However, past studies have demonstrated that ultrasound gels do not have antimicrobial properties and could</p>	S 598	<p>1. On 5/15/15 all refillable bottles of ultrasound gel have been removed from storage and radiology unit. Radiology will only purchase individual bottles from now on.</p> <p>2. Any department that has ultrasound gel will remove all refillable bottles of ultrasound gel from usage and will only purchase individual bottles in the future.</p> <p>3. The process of purchasing refillable ultrasound gel will be discontinued. The infection control manager will be responsible for making sure that all departments are compliant with this standard.</p> <p>4. Starting in May 2015, a monthly audit/walk around by Infection Control will ensure that no refillable bottles of ultrasound gel are being used in any department in the hospital. This</p>	05/15/2015
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	<p>serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA recommends that Ultrasound Gel containers not to be refilled.</p> <p>2. At 2:45 PM on 4/21/2015, the Radiology Department Ultrasound room was inspected. Located in the room was a counter with three 16-ounce ultrasound gel containers inside the counter with a partial bulk plastic container of Aquasonic Ultrasound Gel. On the counter top was an Aquasonic Gel thermal sonic warming unit with plastic bottles warming in the unit.</p> <p>3. At 2:58 PM on 3/4/2014, staff member #21 (Radiology technician) indicated he/she refills the ultrasound gel plastic bottles. The staff member indicated a box containing 1 empty plastic bottle and a bulk plastic container of Aquasonic Ultrasound Gel is received when delivered by the</p>		<p>information will be entered on the PCRC department scorecard. Once 6 months of 100% compliance is reached, discussion at the quarterly meeting will determine whether this item needs to continue to be measured.</p>		

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S 610 Bldg. 00	<p>manufacturer. The empty plastic container would be refilled several times with the bulk container of ultrasound gel until it is empty.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer</p>			

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	<p>temperature monitoring.</p> <p>Based on documentation review, observation, and staff interview, the hospital failed to discard ready-to-eat potentially hazardous food within 7-day cumulative refrigerated storage time period as defined by the Indiana Retail Food Sanitation Requirements, 410 IAC 7-24.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. St. Vincent Frankfort Hospital Food Supply and Storage Procedures (last revised 1/2014) indicated the hospital kitchen shall comply with the Indiana Retail Food Sanitation Requirements, 410 IAC 7-24.</li> <li>2. Indiana Retail Food Sanitation Requirements, 410 IAC 7-24 states, " Refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a retail food</li> </ol>	S 610	<ol style="list-style-type: none"> <li>1. On 4/20/15, all refrigerated cheese that was opened past 7 days and meat that was opened past 30 days was thrown away.</li> <li>2. Dietary will ensure that all refrigerated, ready-to –eat items will be marked with the date by which the food shall be consumed and will not exceed the designated time frame. See the Touchpoint policy B006</li> <li>3. The dietary manager is responsible for the re-education to all dietary staff on 5/13/15 on the marking/ disposing of foods within the appropriate time frames and for completing the monthly audits.</li> <li>4. Starting in May 2015, random monthly audits will be completed by the Touchpoint (dietary) manager to ensure that all ready to eat prepared/packaged food is dated and/or disposed of within the designated timeframe. This information will be entered on the PCRC scorecard. Once 6 months of 100% compliance is reached, discussion at the quarterly meeting will determine whether this item needs to continue to be measured.</li> </ol>	05/13/2015	

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	<p>establishment, to indicate the date or day by which the food shall be consumed on the premises, sold, or and not to exceed 7-days cumulative refrigerated storage time. "</p> <p>3. On 4/20, the following potentially hazardous ready-to-eat assorted food items exceeded the 7-day cumulative refrigerated storage time and should have been discarded: 2 open packages of parmesan cheeses dated 4/6; an open package of shredded cheeses dated 4/6; 6 open packages of sliced American cheeses dated 3/18; 2 containers of Swiss cheeses with no identifying date marking on them; a container containing Blue cheese dated 3/22; and a container of cooked taco meat dated 3/13.</p> <p>4. At 12:00 PM on 4/20/2015, staff member #12 (Foodservice Director/Dietician) confirmed the food that was observed in the walk-in refrigerated units exceeded</p>			

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S 612 Bldg. 00	<p>the 7-day date marking policy.</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.</p> <p>Based on document review, observation, and staff interview, the hospital failed to ensure effective means are used in destroying microorganisms while using the washer for the patient room mop heads; and failed to ensure patient gowns and linens were stored in a clean and sanitary environment of the clean linen storage room.</p> <p>Findings included:</p>	S 612	<p>1. The entire soiled and clean linen rooms have been cleaned including the floors, ceilings, and rafters on 5/22/2015. All chemicals were removed from the clean linen room on 4/22/15. A contract has been signed with Cintas on 5/1/15 for them to provide and sanitize microfiber mop heads. The contract will begin on 6/1/15. Once the contract begins with Cintas to provide the mop heads the Medxcel manager will remove the washer and dryer from the department.</p> <p>2. The Touchpoint (housekeeping manager) will</p>	05/13/2015
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	<p>1. CDC (Centers for Disease Control and Prevention) guidelines for laundry services in health care facilities states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled at a residual of 50-150 ppm (parts per million) during the chlorine bleach cycle."</p> <p>2. At 1:00 PM on 4/21/2015, the soiled linen storage room was inspected. Within the room was a washer and dryer to wash loads of</p>		<p>ensure that all areas including clean/dirty linen rooms will be cleaned and signed off by the person completing the task. All linen carts are to remain covered.</p> <p>3. Re-education will be completed by the housekeeping manager on 5/13/15 keeping clean/dirty linen room clean from debris on the floor/ceilings/rafters. No storing chemicals in the clean linen room. Education provided on the new process that will be starting with the mop heads.</p> <p>4. The touchpoint (housekeeping) manager will complete a monthly audit starting May 2015 to ensure that the dirty/clean linen rooms are being cleaned, linens are stored appropriately. Once 6 months of 100% compliance is reached, discussion at the quarterly meeting will determine whether this item needs to continue to be measured. Cintas will also be added to the PCRC scorecard starting in June 2015 to ensure that they are providing us with clean mop heads.</p>	

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	<p>mop heads that are used in the patient care areas. The floor in the room was heavily soiled with dirt and other soil debris. The washer and dryer are located adjacent to soiled linen carts. The shelves and the ceiling rafters were heavily caked with soil residue. The room was heavily soiled to properly wash and dry clean mop heads for patient care areas.</p> <p>3. At 1:20 PM on 4/21/2015, the clean linen storage room was inspected. The room had 9 linen transport carts. Most of the carts were covered except a couple of the carts exposed clean gowns. There was also a work table in the room that had three stacks of folded patient gowns that were unprotected. Toilet bowl cleaner was sitting on the work table with the patient gowns. The room shelves and rafters were heavily soiled with dirt and other residue. The linen was not stored in a clean and sanitary environment.</p>			

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S 744  Bldg. 00	<p>4. At 1:25 PM on 4/21/2015, staff member #19 (Facilities Manager) indicated the washer was never evaluated for proper temperature and/or usage of chemicals to ensure the mop heads are properly disinfected for patient care areas. The staff member did not have any idea if the washing and drying of mop heads that are used in patient care areas are meeting CDC guidelines for laundry services in health care facilities. The staff member indicated the soiled linen room was not sanitary environment for proper washing and drying of mop heads. The staff member concluded the clean linen storage room was too dirty to store clean patient linen.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on medical record review and interview, the facility failed to ensure all</p>	S 744	1. ED Manager was notified of deficiencies noted during the	05/22/2015			

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	<p>forms were accurate and completely filled out for 14 of 18 patients who were seen in the ED (Emergency Department) (#P1, P3, P4, P5, P13, P14, P15, P16, P17, P18, P19, P20, P24, and P25).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The medical record for patient #P1 indicated an Emergency Nursing Record from 02/18/15 that lacked documentation of a temperature with the admission vital signs and also lacked a temperature and a time for the discharge vital signs.</li> <li>The medical record for patient #P3 indicated an Emergency Nursing Record from 02/24/15 that lacked documentation of vital signs, an oxygen level, a pain level, and a time for the discharge vital signs. The record also indicated physician documentation of "home" for patient disposition, but the patient was actually admitted to the facility.</li> <li>The medical record for patient #P4 indicated an Emergency Nursing Record from 01/16/15 that lacked documentation of vital signs, an oxygen level, a pain level, and a time for the discharge vital signs.</li> <li>The medical record for patient #P5 indicated an Emergency Nursing Record</li> </ol>		<p>medical record review on 4/22/15. A mass email was sent to all ED staff on 4/24/15 from the Chief Nursing Officer to make them aware of the deficiencies that were noted.</p> <ol style="list-style-type: none"> <li>All department managers will notify their staff in a mass email by 5/22/15 about the documentation deficiencies noted during the chart review. This includes complete vital signs at admission/discharge along with the time the vital signs were taken. Reminder to measure the length and head circumference of all children under the age of 2 upon admission; regardless of their diagnosis.</li> <li>The ED manager will send out a mass email to discuss these deficiencies with the ED staff by 5/22/15.</li> <li>The ED manager will begin auditing 30 charts per month in May 2015 to determine whether the following is complete: <ol style="list-style-type: none"> <li>admission/discharge vital signs (HR, BP, RR, TEMP, O2 SAT, PAIN)</li> <li>Time of admission/discharge vitals documented</li> <li>Length and head circumference are documented upon admission for every patient under the age of 2 years.</li> </ol>                     The monthly audit of charts has been added to the PCRC ED Scorecard. This data will be reviewed quarterly with all department managers and senior leadership. The Quality                 </li> </ol>		

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	<p>from 11/24/14 that lacked documentation of a temperature with the discharge vital signs.</p> <p>5. The medical record for patient #P13, a six-month old, indicated an Emergency Nursing Record from 12/16/14 that lacked documentation of a length and head circumference (which were indicated if less than 24 months old) and also lacked a temperature and time with the discharge vital signs.</p> <p>6. The medical record for patient #P14, a five-month old, indicated an Emergency Nursing Record from 12/16/14 that lacked documentation of a length and head circumference and also lacked a temperature with the discharge vital signs.</p> <p>7. The medical record for patient #P15, a one-year old, indicated an Emergency Nursing Record from 12/02/14 that lacked documentation of a length and head circumference and also lacked a time for the discharge vital signs.</p> <p>8. The medical record for patient #P16 indicated an Emergency Physician Record from 12/08/14 that lacked documentation of a disposition time and condition by the physician. The record also lacked documentation of an</p>		<p>department had been previously auditing 30 ED charts per month to check for documented physician disposition condition and time. This information will continue to be audited and is reported every other month at the ERPI meeting. The Director of the ED and ED Manager are given a list of doctor's who had deficiencies in documenting the disposition condition and time.</p>		

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	<p>admission blood pressure and discharge pain level on the Emergency Nursing Record.</p> <p>9. The medical record for patient #P17 indicated an Emergency Nursing Record from 02/02/15 that lacked documentation of a temperature and time with the discharge vital signs.</p> <p>10. The medical record for patient #P18 indicated an Emergency Nursing Record from 02/28/15 that lacked documentation of a blood pressure, temperature, oxygen level, and time with the discharge vital signs.</p> <p>11. The medical record for patient #P19 indicated an Emergency Nursing Record from 02/11/15 that lacked documentation of a pulse, temperature, and time with the discharge vital signs.</p> <p>12. The medical record for patient #P20 indicated an Emergency Nursing Record from 02/03/15 that lacked documentation of a blood pressure, temperature, and time with the discharge vital signs.</p> <p>13. The medical record for patient #P24 indicated an Emergency Nursing Record from 12/17/14 that lacked documentation of a pain level with the admission vital signs and a temperature and time with the</p>			

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S 952 Bldg. 00	<p>discharge vital signs. The record also indicated an Emergency Physician Record that lacked documentation of a condition on disposition by the physician.</p> <p>14. The medical record for patient #P25 indicated an Emergency Nursing Record from 02/11/15 that lacked documentation of a temperature and pain level with the discharge vital signs.</p> <p>15. At 11:15 AM on 04/20/15, staff member #3, the Quality Manager who navigated the EMR (Electronic Medical Record), confirmed the lack of complete and accurate documentation on the medical record forms.</p> <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 policy and procedure review,</p>	S 952	1. The medical surgical	05/22/2015			

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	<p>medical record review, personnel file review, and interview, the facility failed to ensure physician orders and policy were followed regarding blood transfusions for 3 of 5 patients receiving blood transfusions (#P2, P4, and P5) and failed to ensure 5 of 5 RNs (Registered Nurses) received blood administration training (#N1, N2, N3, N4, and N10).</p> <p>Findings included:</p> <p>1. The facility policy "Blood, Administration of Blood and/or Packed Cells", last approved 11/2014, indicated, "C. Blood may only be initiated by an RN, LPN's may monitor and discontinue blood and infuse NS [normal saline]. ...E. Packed cells should be administered over a 2- 4 hour period from the time obtained from the lab, unless the physician orders other time intervals. ...IV. Administration of Blood Transfusion: ...F. Vital signs and lung assessment is to be obtained before blood transfusion is started, 15- 30 minutes after the transfusion has begun, and then upon completion of the transfusion."</p> <p>2. The medical record for patient #P2, an 87 year old female, indicated a physician order on 02/28/15 to transfuse two units of PRBCs (packed red blood cells), each over four hours. The record indicated the</p>		<p>manager was notified on 4/22/15 of the deficiencies noted during the blood transfusion review.</p> <p>2. The deficiencies that were noted during the review were discussed with all nursing managers during manager meeting on 5/13/15. The managers will relay the blood administration deficiencies that were noted during the state board review.</p> <p>3. A Mass email will be sent out by 5/22/15 to all nursing staff demonstrating the proper procedure for blood transfusion along with the blood transfusion policy. Blood transfusion administrations check off will be added to the nursing orientation.</p> <p>4. The nursing educator will have all nurses complete a power-point and a check off by July 1, 2015 using the teach-back method to demonstrate adherence to the MD order for blood administration and the process as stated by our blood administration policy. The nursing educator will also audit whether all nurses have completed blood administration competencies. This information will be reported on the PCRC Scorecard and will get discussed quarterly by department managers and senior leadership.</p>	

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	<p>first unit was started at 1545 hours and completed at 1850 hours, three hours and five minutes later. The second unit was started at 1900 hours and completed at 2145 hours, two hours and 45 minutes later.</p> <p>3. The medical record for patient #P4, an 80 year old male, indicated a physician order on 01/17/15 to transfuse one unit of PRBCs over four hours. The record indicated the unit was started at 0820 hours and completed at 1035 hours, two hours and fifteen minutes later.</p> <p>4. The medical record for patient #P5, a 40 year old female, indicated vital signs were obtained at 2130 hours on 11/22/14 and a unit of PRBCs was started at 2215. The vital signs that were supposed to be taken 15- 30 minutes after the transfusion had begun were documented at 2150 hours, a time before the start of the transfusion.</p> <p>5. At 9:40 AM on 04/21/15, staff member #3, the Quality Manager who navigated the EMR (Electronic Medical Record), confirmed the medical record findings and confirmed the blood transfusions were not administered according to the physician orders.</p> <p>6. Review of the personnel files for five</p>			

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S 014 Bldg. 00	<p>RNs, #N1, N2, N3, N4, and N10, failed to indicate any blood administration training or competencies.</p> <p>7. At 12:25 PM on 04/22/15, staff members #1, the Chief Nursing Officer, and #2, the Human Resources Director, confirmed they could not provide documentation of blood administration training or competencies for the nurses reviewed.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on policy and procedure review, observation, and interview, the facility failed to follow its pharmacy policy regarding multidose medications.</p> <p>Findings included:</p> <p>1. The facility policy "Multiple Dose Containers", last revised 02/2014, indicated, "1. When a multiple dose vial is used, a 'Do Not Use After' date must be</p>	S 014	<p>1. The multi-dose vials of 1 % lidocaine with epi and 1% lidocaine that were found in the ED were discarded on 4/20/15.</p> <p>2. All managers were notified on 5/13/15 during the manager's meeting that all multi-dose vials must be clearly labeled with a "Do not use after" date that is within 28 days of the vial being opened. All managers will relay this information to their staff through a mass email by 5/22/15.</p> <p>3. Re-education will be</p>	05/22/2015			

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S 118  Bldg. 00	<p>clearly noted on the vial using stickers provided. The vial will expire 28 days from the date opened unless the manufacturer can provide data that would extend that date. Every effort should be made to use any open vials of a medication before a new vial is opened."</p> <p>2. During the tour of the ED (Emergency Department) at 1:15 PM on 04/20/15, accompanied by staff members #1, the CNO (Chief Nursing Officer), and #8, the ED Manager, the following medications were observed in the drawer of the suture cart:</p> <p>A. One of one open, but not dated, 20 milliliter vial of 1% Lidocaine with Epinephrine.</p> <p>B. Three of three open, but not dated, 20 milliliter vials of 1% Lidocaine.</p> <p>3. At 1:15 PM on 04/20/15, staff member #8 indicated the vials should have been dated when opened.</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</p>		<p>completed by the managers through a mass email by 5/22/15 to all staff about the "Multiple Dose Container Policy." The email will clearly define that all multi-dose vials must be clearly labeled with a "Do not use after" date that is within 28 days of the vial being opened.</p> <p>4. The ED manager will be responsible for this measure and will audit medication carts/pyxis through random monthly audits and will report the data on the PCRC Scorecard. The PCRC Scorecard will be reviewed quarterly during our meetings with all department managers and senior leadership.</p>		

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	<p>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 staff interview, the hospital failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in six (6) instances.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>St. Vincent Frankfort Hospital Safety Committee: Organization/Duties (last revised 3/2015) indicated the the hospital-wide safety program shall comply with OSHA (Occupational Safety and Health Administration) requirements.</li> <li>OSHA considers the guidelines set by such sources as American National Standards Institute proper</li> </ol>	S 118	<ol style="list-style-type: none"> <li>Med-Excel (our maintenance group) will add the weekly inspection to their responsibility list for the following eye wash stations: ED-dirty utility room, Lab, Radiology/ultrasound, and the Boiler room. Maintenance department made the boiler room eyewash station accessible. Thermometers were added to the med-surg, ED and surgery blanket warmers along with temperature logs on 5/15/15.</li> <li>Med-Excel will add the weekly inspection of all hospital eye wash stations to their list of responsibilities. All blanket/fluid warmers will have a thermometer and the temperature will be tracked daily by the unit's staff members.</li> <li>Temperature log was created and placed by all blanket warmers on 5/15/15. Unit staff members will track the daily temperatures with instructions to keep &lt;130 degrees and to decrease the temp daily until the warmer reaches the appropriate temperature. We will also add to the policy that all blanket warmers will be kept at a temperature of less than or equal to 130</li> </ol>	05/22/2015

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	<p>maintenance and weekly testing is necessary to ensure that Emergency Drench Showers and Eyewash Stations are functioning safely and properly. Weekly testing helps clear the supply lines of sediment and bacteria build-up that is caused from stagnant water. The ANSI standard states that plumbed flushing equipment, "shall be activated weekly for a period long enough to verify operation and ensure that flushing fluid is available". Furthermore, the ANSI Z358.1-2009 standard also requires Portable and Self Contained equipment be visually checked to determine if flushing fluid needs to be changed or supplemented. The eyewash station and or shower combo has to be easily accessible at all times.</p> <p>3. At 1:30 PM on 4/20/2015, the Emergency Department Decontamination Room was observed with the eyewash station's weekly inspection tag noted that it's last visual check was</p>		<p>degrees. Med-Excel will complete all weekly inspections of all hospital eye wash stations.</p> <p>4. The Quality manager is responsible for making sure the temperature of the warmers is documented daily by the department's staff members. The department managers will assist in tracking this data on a monthly basis. Med-Excel will complete all weekly inspections of eye wash stations and this will be added to the PCRC department scorecards, which will be discussed quarterly with all department managers and senior leadership. The MedExcel manager is responsible for making sure all eye wash stations are being checked weekly.</p>		

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	<p>11/1/2012. Staff member #1 (Chief Nursing Officer) and staff member #8 (Emergency Department Manager) were present when the decontamination's eyewash station's inspection tag evidenced that it was not visually inspected weekly.</p> <p>4. At 12:35 PM on 4/21/2015, the Laboratory Microbiology Department was observed with a faucet adapter eyewash station connected to the faucet of a dirty utility sink. Furthermore, a string connected to a scrub brush was tied on the eyewash station arm. Staff member #22 (Laboratory Technician) was present and confirmed the sink was a dirty utility sink. Therefore, the eyewash had the possibility of contaminants splashing in someone's eyes if the eyewash station needs to be used immediately.</p> <p>5. At 12:50 PM on 4/21/2015, the Radiology Ultrasound's eyewash</p>			

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NAME OF PROVIDER OR SUPPLIER  ST VINCENT FRANKFORT HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 S JACKSON ST FRANKFORT, IN 46041
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	<p>station was observed without any weekly inspection tag of visual inspections available upon request. Staff member #22 (Radiology Technician) was present during the inspection confirming the absence of an inspection tag.</p> <p>6. At 1:45 PM on 4/21/2015, the Boiler Room's eyewash station was observed blocked by a blue 55-gallon drum containing a chemical. Staff member #19 (Facilities Manager) was present during the tour and witnessed the eyewash station was not easily accessible.</p> <p>7. At 1:50 PM on 4/21/2015, the Maintenance Room's eyewash station was observed blocked by assorted maintenance tools and supplies. Staff member #19 (Facilities Manager) was present during the tour and witnessed the eyewash station was not easily accessible.</p> <p>8. During the tour of the Med/Surg Unit at 12:15 PM on 04/20/15,</p>			

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	<p>accompanied by staff members #1, the CNO (Chief Nursing Officer), and staff member #5, the Unit Manager, a Pedigo warming unit containing only blankets was observed registering 186 degrees F (Fahrenheit). No temperature monitoring log was available or provided by staff. Staff member #5 indicated staff did not keep a temperature monitoring log.</p> <p>9. During the tour of the ED (Emergency Department) at 1:00 PM on 04/20/15, accompanied by staff member #1 and staff member #8, the ED Manager, a warming unit containing only blankets was observed with a dial set at '10', the highest setting. There was no thermometer or device to determine the actual temperature of the unit. Staff member #8 indicated the staff did not monitor the temperature of the unit.</p> <p>10. During the tour of the Surgical Recovery Room at 2:15 PM on 04/20/15, accompanied by staff</p>			

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	<p>member #9, the Unit Manager, a warming unit containing only blankets was observed with the temperature registering 103 degrees F. Staff member #9 indicated the staff did not monitor the temperature of the unit.</p> <p>11. At 11:30 AM on 04/21/15, staff member #1, confirmed the facility followed AORN (Association of periOperative Nurses) guidelines which indicated warming temperatures for blankets or other patient linens should not exceed 130 degrees F. The guidelines also indicated solutions, blankets, and patient linens should be stored in separate warming cabinets or in separate compartments with independent temperature controls and temperatures should be set, maintained, monitored, and documented according to organizational policy. Staff member #1 confirmed the facility had a policy for warming fluids, but not for warming just blankets</p>			

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S 162 Bldg. 00	<p>or monitoring those units.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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>(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.</p> <p>Based on documentation review, the facility failed to comply with manufacturer recommendations for the Physical Therapy's hydrocollator.</p> <p>Findings included:</p> <p>1. The Operation Manual instructions for the use and operation for Chattanooga Hydrocollator M-2 Master Heating Unit notes the thermostats are extremely sensitive and the</p>	S 162	<p>1. The Physical Therapy department was made aware on 5/19/15 that the hydrocollator temperature exceeded 166 degrees 12 out of 13 days in April. The Physical therapy staff will monitor and adjust the hydrocollator to keep the temperature between 160-166 degrees.</p> <p>2. There is only one hydrocollator in the hospital and it is located in the physical therapy department.</p> <p>3. The physical therapy department will not only record the hydrocollator temperature daily but will adjust it as needed to get the temperature within the 160-166 degree allowable range.</p>	05/19/2015
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S 164 Bldg. 00	<p>slightest adjustment will alter the temperature several degrees. Operating Temperature for all models is 160 to 166 degrees Fahrenheit.</p> <p>2. The April Hot Pack Hydrocollator Temperature log evidenced the recorded temperature exceeded 166 degrees Fahrenheit 12 (04/02-03, 04/08-10, 04/13-17, 04/20-21/15) out of 13 days that were recorded on the April 2015 log.</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.</p> <p>Based on document review and</p>	S 164	<p>4. The physical therapy manager is responsible for reviewing and tracking the temperature logs to determine whether daily temperature checks were completed and if corrective actions were documented to keep the hydrocollator within the appropriate temperature of 160-166 degrees. This information will be added to the physical therapy section of the PCRC scorecard and will be discussed quarterly with all department managers and senior leadership.</p> <p>1. The Med-Excel (facilities department) added the physical</p>	05/15/2015	

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	<p>staff interview, the facility failed to ensure preventive maintenance was conducted on Environmental Service's floor scrubbers and Physical Therapy's rehabilitation wooden steps.</p> <p>Findings included:</p> <p>1 The hospital preventive maintenance logs lacked evidence of preventive maintenance being conducted on the Physical Therapy Rehabilitation wooden steps and the industrial floor scrubbers.</p> <p>2 At 10:30 AM on 4/21/2015, staff member #8 (Facility Supervisor) confirmed the Rehabilitation wooden steps and the industrial floor scrubbers were not on a preventive maintenance schedule.</p>		<p>therapy's rehabilitation wooden steps and the industrial floor scrubbers to their priority list as of 5/15/15.</p> <p>2. The manager of the facilities department will meet annually with each department manager to make sure all equipment is having preventative maintenance completed.</p> <p>3. The department managers should notify the manager of Med-Excel if new equipment comes in that requires preventative maintenance completed. Med-Excel team has added the physical therapies rehabilitation wooden steps to their preventative maintenance list as of 5/15/15. Med Excel will complete the preventative maintenance for the industrial floor scrubber and the wooden steps.</p> <p>4. The Med-Excel manager will track the completion of the preventative maintenance on the wooden steps and the industrial floor scrubber starting by May 22, 2015 and will ensure that they remain on a regular preventative maintenance schedule. The preventative maintenance logs will be kept in the Med-excel office.</p>		