

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2016
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
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S 0000 Bldg. 00	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 3/14/2016 to 3/16/2016</p> <p>Facility Number: 005021</p> <p>QA: cjl 04/29/16</p>	S 0000		
S 0406 Bldg. 00	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(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:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and</p>	S 0406	QA&I data for the post-operative	05/31/2016

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>interview, the hospital failed to ensure two services (Post-Operative Recovery and Central Processing/Sterile) were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the Franciscan St. Elizabeth Health-Crawfordsville Quality Assurance & Performance Improvement Program Plan indicated "All programs, departments, and services participate in the QAPI Program. Activities and projects, in accordance with the program scope, are ongoing and based on quality indicators and identified opportunities for improvement." The QAPI Plan was last reviewed 10/13/2015. 2. Review of the Hospital Quality and Patient Safety committee dashboards and minutes for 2015 indicated lack of documentation that Post-Operative Recovery and Central Processing/Sterile were evaluated or addressed. 3. In interview at 10:00 AM on 3/16/2016, staff member #5 (Director Quality Management) confirmed all the above and no other documentation was provided prior to exit. 		<p>recovery and central processing/sterile departments were received as of 4/31/2016 To assist with ongoing compliance efforts a tracking system was implemented as of 5/1/2016 Departments will receive notification of monthly/quarterly reporting status. Senior leadership will be notified for any department non-compliance and take further corrective action This coincides with the 5/1/2016 tracking process The Director of Quality will be responsible for ensuring the tracking, reporting, and compliance efforts are implements/met Examples of the data received and tracking system are attached to this response</p>				

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S 0418 Bldg. 00	<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 interview, the hospital failed to document an action plan to address the opportunities for improvement for 3 services and 1 function in the hospital's quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Review of Franciscan St. Elizabeth Health-Crawfordsville QAPI Plan indicated "The QAPI program activities give consideration to prevalence,</p>	S 0418	<p>QA&I data action plans for deficiencies were received as of 5/12/2016 To assist with ongoing compliance efforts a tracking system was implemented as of 5/1/2016 Education of all department leadership on action plan requirements will be completed by 5/31/2016 Departments will receive notification of monthly/quarterly reporting status. Senior leadership will be notified for any department non-compliance and take further corrective action This coincides with the 5/1/2016 tracking process</p>	05/31/2016	

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	<p>severity, science, measurability and opportunity to improve care by identified opportunities for improvement. The action plan will include what is expected to occur, who is responsible, and related timeframes." The QAPI Plan was last reviewed 10/13/2015.</p> <p>2. Review of 3 services and 1 function of the hospital's QAPI program dashboards indicated lack of evidence of written action plans for areas that fell short of their goals.</p> <p>A. Discharge Planning Function: percent initial discharge plans started within 24 hours of admit</p> <p>B. Therapy Services: Percentage of patients scheduled five or more days after their referral</p> <p>C. Dietary Services: Food Temps on traylines</p> <p>D. Laboratory Services: Mislabeled Specimens</p> <p>3. In interview at 2:30 PM on 3/15/2016, staff member #5 (Quality Director) confirmed all the above and no other documentation was provided prior to exit.</p>		The Director of Quality will be responsible for ensuring the tracking, reporting, and compliance efforts are implements/met Examples of the data received and tracking system are attached to this response		

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S 0566 Bldg. 00	<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 interview, the chief executive officer, medical staff and the executive nurse failed to ensure a successful corrective action was implemented in response to a failure to perform and report monthly nursing unit-based hand hygiene compliance monitoring to the infection control (IC) committee for two nursing units in 2015 (Emergency Department (ED) and Generations geriatric mental health unit).</p>	S 0566	<p>The Infection Control (IC) Manager completed one-to-one education with the managers of the Emergency and Generations Departments as of 4/31/2016 The IC department will implement a tracking system for the required monthly reports and communicate delinquent departments to the appropriate senior leader Details will be reported and discussed at the appropriate IC meeting A Hand-washing compliance computer based training module</p>	05/31/2016

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. The policy/procedure Hand Hygiene Procedure (approved 3-13) indicated the following: "Soap and water and hand sanitizer are used for hand hygiene...Hand hygiene should be performed...before and after patient contact..." 2. The IC committee minutes dated 1-15-15 indicated the following: "Hand hygiene - continues to be a corporate initiative, and the goal is 90% compliance. Any department that is non-compliant with the goal will be required to complete remedial education and have quarterly goal set until 90% is reached. Continued compliance below 90% will require the department manager to provide the committee with an action plan." 3. The IC committee minutes dated 5-28-15 indicated the following: "...an update on Hand Hygiene stating that in order to meet corporate initiative each Department Manager needs to make sure they are monitoring Hand Hygiene in their department to complete the log with at least 20 observations ...[and]... no actions were necessary; we continue to work with each department." 		<p>will be developed by 5/31/2016 This training module will be used as the education needed for those in non-compliance The IC Manager will be responsible for this improvement process</p>				

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	<p>4. The IC committee minutes dated 7-30-15 indicated the following: "an update on Hand Hygiene stating that the Hand Hygiene rates have decreased as we continue working on compliance with obtaining hand hygiene audits from departments ...[and]... we continue to work with each department."</p> <p>5. The IC committee minutes dated 9-24-15 indicated the following: "...no actions were necessary; we continue to work with each department..." and failed to indicate no hand hygiene audits were performed in 2015 the Generations unit or since March for the ED.</p> <p>6. The IC committee minutes dated 11-19-15 indicated the following: "No updates on Hand Hygiene at this time. The Committee discussed the importance of Hand Hygiene and emphasized that this should continue to be a major focus by the Infection Control Committee ... [and]... we continue to work with each department. Emphasis was placed on the need to have data reported to the IC department by the 5th of each month." The minutes failed to indicate no hand hygiene audits were performed in 2015 for the Generations unit or since March for the ED.</p>			

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S 0584 Bldg. 00	<p>7. The IC committee minutes dated 1-21-16 indicated the following: "Hand Hygiene reports through December 2015. The Committee discussed the importance of Hand Hygiene and emphasized that this should continue to be a major focus by the Infection Control Committee ... [and]... no actions were necessary." The IC committee minutes failed to indicate no hand hygiene audits were performed in 2015 for the Generations unit or since March for the ED and failed to indicate a corrective action was implemented in response to the lack of hand hygiene compliance monitoring.</p> <p>8. On 3-17-16 at 1720 hours, the infection control nurse, staff A14, confirmed the IC minutes failed to indicate a successful corrective action was implemented in response to the failure of the Generations and ED nursing units to conduct and report hand hygiene compliance monitoring in 2015.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(3)(A)</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</p>				

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	<p>not be limited to, the following:</p> <p>(A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the hospital.</p> <p>Based on document review and interview, the infection control (IC) committee failed to ensure that all surgical patients were evaluated for surgical site infections (SSIs) by a qualified medical provider and reported and reviewed through the IC program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The policy/procedure infection Control Plan Policy (reviewed 1-16) indicated the following: "Methods of Surveillance: ... Surgical Site Infections... Post discharge surveillance performed quarterly: # of Infections." The methodology or process for evaluating all post-surgical patients for SSIs could not be determined by the indicated information. 2. On 3-15-16 at 1010 hours, the infection control nurse, staff A4, was requested to provide a description of the process for monitoring all surgical patients for SSIs and no documentation was received prior to exit. 3. During an interview on 3-15-16 at 	S 0584	<p>Review of the infection control program policy/plan was completed as of 4/31/2016 to ensure practices outlined were in alignment with current best practices By 5/31/2016 staff needed to complete the notification to physician regarding the needed evaluations will be designated By 6/30/2016 computer reports will be available to identify the cases needed further evaluation By 7/31/2016 evaluation requests will be mailed to physicians Results of the returns will be discussed by the infection control committee for further action as indicated For ongoing evaluation, requests will be sent quarterly with a summary of responses presents to the Infection Control Committee</p> <p>The IC Manager will be responsible for this improvement process</p>	07/31/2016

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S 0590 Bldg. 00	<p>1010 hours, the IC nurse, staff A4, confirmed that a written description of the SSI monitoring process was not available. The IC nurse A4 indicated they (A4) received monthly reports of patients having surgical procedures at the facility and reviewed all positive laboratory culture results of surgical site infections. The IC nurse A4 confirmed they (A4) were not submitting or receiving a monthly list of surgical patients to/from each surgeon for identification of all SSIs or potential SSIs diagnosed and treated with appropriate antimicrobial therapy by the medical staff provider and confirmed that the current SSI monitoring process failed to assure 100% of all surgical patients were monitored for surgical site infections through the IC program.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(C)</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:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.</p>			

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	<p>Based on document review and interview, the infection control committee failed to document the review of employee exposure events with appropriate recommendations to minimize risk if indicated for 8 blood and body fluid (BBF) exposure events in 2015.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy/procedure Bloodborne Pathogen Exposure Plan Procedure (approved 1-16) indicated the following: "The Employee Health Office will be responsible for immunization, exposure follow up, and evaluation. This will be reported to the Infection Control (IC) department." On 3-24-16 at 1500 hours, the employee health nurse, staff A14 provided documentation of 2015 BBF exposure events indicating 2 BBF events and one potential Tuberculosis (Tb) exposure in March, 1 BBF exposure event in June, 2 BBF exposure events in July, and 1 BBF exposure in November, 2015. The 1-15-15, 3-19-15, and 5-28-15 IC committee meeting minutes failed to indicate a January 2015 BBF exposure event identified on the 1-21-16 IC 	S 0590	<p>One-to-one discussion between the Infection Control Manager and the Employee Health Manager regarding attendance and participation with the Infection Control Committee (ICC) occurred prior to 4/30/2016 ICC agenda will include the standing report from employee health</p> <p>The ICC minutes will be expanded to provide details of the loop-closure on the employee health cases, as warranted</p> <p>The Infection Control Manager will be responsible for the detailed documentation in the minutes</p> <p>The Manager of Employee Health will be responsible for employee health representation and documentation at the ICC meetings</p>	05/31/2016			

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	<p>minutes bar graph of all 2015 BBF events. The 1-15-15 and 3-19-15 IC minutes indicated the employee health nurse, staff A14 was not present and indicated the following: "No report was available."</p> <p>4. The 5-28-15 IC minutes indicated the employee health nurse, staff A14 attended the IC committee meeting and indicated: "[Staff A14] reported that there were two exposures in March 2015...[and] ...[Staff A14] reported there was a potential for exposure to Tuberculosis (Tb) in March 2015 ..." and no documentation indicated an IC committee discussion, review, or recommendation regarding the 2 BBF events or the outcome of the investigation regarding the 10 personnel potentially exposed to Tb.</p> <p>5. The 7-30-15 IC minutes indicated the employee health nurse, staff A14 was not present and indicated the following: "Nothing to report at this time."</p> <p>6. The 9-24-15 IC minutes indicated the employee health nurse, staff A14 was not present and indicated the following: "There was one BBF exposure reported for the month of June 2015 and two for the month of July 2015 ..." and no documentation indicated an IC committee</p>			

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S 0602 Bldg. 00	<p>discussion, review, or recommendation regarding the BBF event in June or the 2 BBF events in July.</p> <p>7. The 11-19-15 IC minutes indicated the employee health nurse, staff A14 was not present and indicated the following: "There have been no BBF exposures reported since July 2015."</p> <p>8. The 1-21-16 IC minutes indicated the employee health nurse, staff A14 was present and indicated the following: "There have been no BBF exposures reported since November 2015."</p> <p>9. During an interview on 3-16-16 at 1150 hours, the IC nurse, staff A4, confirmed the IC minutes lacked documentation of a discussion, action, or recommendation regarding the BBF exposure events in 2015.</p> <p>10. During an interview on 3-16-16 at 1550 hours, the director of quality, staff A9, and the employee health nurse, staff A14 confirmed the IC minutes lacked documentation of a discussion, action or recommendation regarding the BBF exposure events in 2015.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(vi)</p>				

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	<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>(vi) An isolation system. Based on document review, observation and interview, the infection control (IC) committee failed to ensure an effective cleaning product was immediately available for use with isolation patients diagnosed with the communicable disease Clostridium difficile (C diff) at the facility.</p> <p>Findings include:</p> <p>1. The Infection Control and Hospital Epidemiology publication titled 'Strategies to Prevent Clostridium difficile Infections in Acute Care Hospitals: 2014 Update' indicated the following: "C. difficile now rivals methicillin-resistant Staphylococcus aureus (MRSA) as the most common organism to cause healthcare-associated infections (HAIs) in the United States... [and]... Perform environmental decontamination of rooms of patients</p>	S 0602	<p>The product needed for staff use in relationship to patients with c-diff was identified/selected prior to 4/30/2016 Staff education regarding the product and purpose will be completed by 5/31/2016 The product order has been placed and is expected to be in-house by 5/31/2016 Product will be dispersed to the clinical units as soon as they arrive. We believe the product will be added to the appropriate clinical areas inventory no later than 6/30/2016 The Infection Control Manager will be responsible for ensuring the product is available to all staff and education has been completed</p>	06/30/2016

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	<p>with Clostridium difficile using sodium hypochlorite (household bleach) diluted 1:10 with water or an Environmental Protection Agency (EPA)-approved sporicidal product..."</p> <p>2. The policy/procedure Isolation Program Procedure (approved 11-15) indicated the following: "...use Enteric Contact Precautions for specified patients known or suspected to be infected with... Clostridium difficile (C.diff)... patient transport... wipe the bed rail and head board/foot board with disinfectant wipe... If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another patient... Reusable items will be wiped down with the hospital-approved disinfectant, bagged and sent to Central Sterile. Housekeeping will clean the outside of the isolation cart." Based on a review of the policy/procedure, it could not be determined what disinfectant product was approved for cleaning and disinfecting the bed surfaces or patient care equipment before use with another patient and it could not be determined if/how an isolation cart was available for use with all enteric contact isolation patients.</p> <p>3. During a tour of the medical surgical (MS) unit on 3-15-16 at 1512 hours, in</p>			

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S 1118 Bldg. 00	<p>the presence of the infection control nurse, staff A4, and the MS unit manager, staff A15, the patient care hallway was observed with an isolation cart outside of room 217 together with a sign indicating that Enteric Isolation Precautions were in effect. It was observed that no cleaning or disinfecting products were present on the top of the isolation cart and the bottom drawer contained two containers of quaternary ammonium-based, purple-topped PDI Super Sani Wipes.</p> <p>4. During an interview on 3-15-16 at 1512 hours, the infection control nurse, staff A4, and the MS manager, staff A15, confirmed the PDI Super Sani Wipes were not effective for disinfection when enteric isolation precautions were in effect and confirmed that no other disinfecting products were available for use by staff if needed.</p> <p>5. During an interview on 3-16-16 at 1010 hours, the director of quality, staff A9, confirmed that bleach-based disinfecting wipes were not available for use at the facility.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p>						

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	<p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation and interview, the facility failed to ensure fully charged spare batteries were available for defibrillators for 4 of 4 defibrillators and failed to ensure the physical environment was maintained to minimize the risk of hazards to patients and personnel for its surgical services department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of Zoll-M defibrillator operator's manual section 9 indicated "Fully charged spare battery available." 2. During the tour of the hospital at 10:00 AM on 3/15/2016, four defibrillators were observed not having a spare battery available: Emergency Department (ER) room #213; ER hallway; Med/Surgery; and Intensive Care Unit (ICU). 3. In interview at 11:30 AM on 	S 1118	<p>To ensure a fully charged defibrillator is available to all areas of the hospital in case of a failed battery, a complete spare defibrillator is available 24/7 in the Central Supply area All staff have access to this area 24/7 The Safety Officer will ensure the defibrillator checks are made daily per the manufacturer guidelines The spare defibrillator was available and ready for use by 3/31/2016</p> <p>Auto-closures on the operating room doors were installed on 3/20/2016. The operating room director is responsible for reporting any malfunctions of the devices to maintenance for repairs.</p>	03/31/2016	

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S 1160 Bldg. 00	<p>3/15/2016, staff member #22 (Bioengineer) indicated the hospital does not have any spare batteries available for any defibrillator within the hospital.</p> <p>4. During a tour of the surgical areas on 3-15-16 at 1410 hours, in the presence of the infection control (IC) nurse, staff A4, and the surgical services manager, staff A11, the entry door to the operating room #3 (OR #3) was observed without an automatic door closer and at 1420 hours, the entry door to the OR #2 was observed without an automatic door closer. Due to the lack of door closer units, it could not be determined that the fire code requirements and/or special ventilation requirements for the operating rooms and surrounding areas were maintained when patients were present for surgery at the facility.</p> <p>5. During an interview on 3-15-16 at 1420 hours, the surgical services manager, staff A11, confirmed that the door closer units were removed in 2015 and not repaired or replaced.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p>			

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	<p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on observation and document review, the facility failed to ensure its equipment was maintained in good working order for two blanket warmers observed on tour.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a tour of the emergency department (ED) on 3-15-16 at 1300 hours, in the company of the infection control (IC) nurse, staff A4, and the ED manager, staff A11, the presence of accumulated dust was observed in the heating element area under the plenum of a Blickman cabinet type blanket warmer. 2. During a tour of the surgery services on 3-15-16 at 1340 hours, in the company of the infection control (IC) nurse, staff A4, and the surgical services manager, staff A11, the presence of accumulated dust was observed in the circulating fan area between the upper and lower portions of a Getinge Castle cabinet type blanket warmer. 3. Review of biomedical preventive maintenance documentation dated 3-15 for warming cabinets lacked an indication for periodic dust removal. 	S 1160	<p>A new procedure for quarterly preventative maintenance for cleaning of warming cabinets has been developed and will be routed for signatures via the appropriate committees Staff were educated on this new process via staff meetings in April. Monitoring will occur every six (6) months as part of the preventative maintenance program. The Physical Plant Manager and Biomedical Manager will ensure this new preventative maintenance policy is implemented and that the scheduled checks are completed Final safety committee review and signatures for the process are expected to be obtained by June 30</p>	06/30/2016

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S 1168 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on documentation review and interview, the hospital failed to ensure the Zoll M-series Defibrillator was discharged on every 12-hour shift in 4 of 4 patient-care/treatment areas.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of Franciscan St. Elizabeth Health-Crawfordsville Routine Checking of Zoll Biphasic and Monophasic Demand Defibrillators policy indicated "The defibrillators will be tested each shift and documented by designated staff when the department is in use." The policy was last reviewed 10/30/2015. Review of Daily Crash Cart Checklist indicated four 24/7 patient care areas did not consistently discharge the defibrillator every 12-hour shift. <p>A. Review of January and February</p>	S 1168	<p>All departments began checking the defibrillators q12 hours the day of the survey findings All staff were reminded of this change at staff meetings that occurred prior to the end of March</p> <p>The VP/COO reports that current efforts are to replace all defibs with more updated models which will require once-a-day check The date of this transition is not currently known; therefore, until this occurs the staff will continue to conduct q12 hour checks</p> <p>The department managers for the units housing a defibrillator will be responsible for ensuring the checks are completed q12</p>	03/31/2016	

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S 1172	<p>Emergency Department (ER) room #213 defibrillator Daily Crash Cart Checklist noted 24 days were lacking 1 or both 12-hour shift's discharge documentation.</p> <p>B. Review of January and February ER outer hallway defibrillator Daily Crash Cart Checklist noted 13 days were lacking 1 or both 12-hour shift's discharge documentation.</p> <p>C. Review of January and February Med/Surgery Department's defibrillator Daily Crash Cart Checklist noted 12 days were lacking 1 or both 12-hour shift's discharge documentation.</p> <p>D. Review of January and February Intensive Care Unit defibrillator Daily Crash Cart Checklist noted 14 days were lacking 1 or both 12-hour shift's discharge documentation.</p> <p>3. In interview at 2:15 PM on 3/15/2016, staff member #1 (Materials Manager) confirmed all the above and no other documentation was provided prior to exit.</p>			
	410 IAC 15-1.5-8			

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Bldg. 00	<p>PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation and interview, the environmental services failed to ensure its surgical environment was maintained in a sanitary manner and ensure its patient care areas including ventilation grilles were free of dust at the facility.</p> <p>Findings include:</p> <p>1. During a tour of the outpatient surgery services on 3-14-16 at 1630 hours, in the company of the surgical services manager, staff A11, the presence of accumulated dust was observed on an 8" x 24" ceiling ventilation grille in the pre and post-op room #s 7 and 8.</p> <p>2. During a tour of the outpatient surgery</p>	S 1172	<p>All ceiling ventilation grilles have been cleaned as of March 31 . The accumulated dust on top of an automatic door closer was cleaned as of March 16 The Environmental Services Department in conjunction with the Physical Plant staff will incorporate cleaning of the grilles into their routine processes A preventative maintenance process has been established that includes routine cleaning every six (6) months. The manager of environmental services will be responsible to ensure the grilles are kept clean</p>	03/31/2016	

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	<p>services on 3-14-16 at 1630 hours, in the company of the surgical services manager, staff A11, the presence of accumulated dust was observed on the top of an automatic door closer unit in the operating room #2.</p> <p>3. During a tour of the emergency department (ED) on 3-15-16 at 1240 hours, in the company of the infection control (IC) nurse, staff A4, and the ED manager, staff A11, the presence of accumulated dust was observed on a 16" x 24" ceiling ventilation grille in the nursing station area directly over the Indiana Hospital Emergency Radio Network (IHERN) radio equipment.</p> <p>4. During a tour of the emergency department (ED) on 3-15-16 at 1255 hours, in the company of the infection control (IC) nurse, staff A4, and the ED manager, staff A11, the presence of accumulated dust was observed on a 16" x 24" ceiling ventilation grille in the treatment room #1.</p> <p>5. During a tour of the emergency department (ED) on 3-15-16 at 1310 hours, in the company of the infection control (IC) nurse, staff A4, and the ED manager, staff A11, the presence of accumulated dust was observed on an 8" x 24" ceiling ventilation grille in the</p>			

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	soiled utility room. 6. On 3-15-16 at 1530 hours, the director of quality, staff A9, was requested to provide a policy/procedure and documentation of periodic ventilator grille cleaning and none was received prior to exit.				