

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036
---------------------------------------------------------------	--------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005083</p> <p>Survey Date: 04-17-12 to 04-18-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson, BS ASCPMT Medical Surveyor 3</p> <p>QA: claughlin 04/25/12</p> <p>6/22/12 revised due to IDR</p>	S0000	<p>Preparation and/or execution of this Plan of Correction does not constitute an admission by St.Vincent Mercy Hospital of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by state law. We intend for the Plan of Correction to serve as St.Vincent Mercy's evidence of compliance.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 personnel file review and interview, the facility failed to ensure that state rules and regulations were complied with in reference to IC 16-28-13 for 1 nurse aide and 2 emergency department technician personnel files reviewed (P1, P6 and P7).</p> <p>Findings: 1. review of IC 16-28-13-4 indicated that: a. "Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or (2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for 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 10-13-3 or another source by law."</p>	S0102	<p>The Manager of Human Resources conducts a registry check on all persons pending an employment offer as a nurse aide or other unlicensed employee. Any individual that has been convicted of any of the following are not employed: a sex crime; exploitation of an endangered adult; failure to report battery, neglect, or exploitation of an endangered adult; theft; murder; voluntary manslaughter; involuntary manslaughter; felony battery; felony offense relating to controlled substances; any person that has abused, neglected, or mistreated a patient or misappropriated a patient's property, and had a finding entered into the state nurse aide registry. St.Vincent Mercy hospital does not require its nursing assistants to be certified. When the nurse aide registry is queried for individuals not in the nurse aide registry database, a blank search result form is returned. When a query produced a blank finding form, it has not historically been placed in the associate's file. For staff members P1, P6 and P7 the registry search was completed on April 19 th and the</p>	04/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. at 9:10 AM and 1:10 PM on 4/18/12, review of personnel files indicated:</p> <p>a. medical/surgical unit nurse aide P1 was hired 2/12/08 and was lacking documentation of a search of the home health aide registry site</p> <p>b. two emergency department techs were hired 6/24/11 and were lacking documentation of a search of the home health aide registry site</p> <p>3. interview with staff member #53 at 11:05 AM on 4/18/12 indicated:</p> <p>a. no registry check documentation could be found for staff members P1, P6 or P7</p> <p>b. this staff member conducts a registry check search, but has not been placing documentation in the employee files for others to be sure this had been completed</p>		<p>search findings form placed in their respective personnel files to document that the search was conducted. In addition, the Manager of Human Resources conducted a registry check on all facility nursing assistants to ensure that their personnel files had documentation that the search of the nurse aide registry had been conducted. The Manager of Human Resources will annually audit personnel files to ensure that the required documentation is present for others to be sure that the nurse aide registry check was completed and documented. The Human Resources Manager is responsible for reporting at least annually to the Operating Board compliance with conducting the required registry checks on unlicensed employees and filing documentation in the associates personnel file.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0314	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(E)(i)(ii)(iii)</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>(E) Establishing criteria for each service manager, department director or supervisor that includes, but is not limited to, the following:</p> <p>(i) Definition of educational requirements. (ii) Experience requirements. (iii) Professional certification, licensing, or registration, where appropriate.</p> <p>Based on policy review, personnel file review, and interview, the facility failed to ensure that 5 of 13 staff members participated in mandatory infection control and fire/life safety inservices in 2011, or to date in 2012 (staff members #P2, P3, P8, P11 and P12).</p> <p>Findings: 1. at 12:15 PM on 4/18/12, review of the policy "Education Programs" with a Policy ID number of 106726, indicated: a. under "Procedure", it reads: "...B. Reporting: Corporate Mandatory web-based training shall be completed on</p>	S0314	<p>Staff members P2, P3, P8, P11, and P12 were scheduled time by their respective managers to complete the required annual mandatory training on Infection Control and Fire and Life Safety as needed. The training was completed by each of these individuals on or before May 10, 2012. The organization's policy on Performance Evaluation was revised and states that <i>"Associates that have not completed their annual mandatory WBTs in SEED are not eligible for merit increases and will NOT be scheduled to work until all mandatory training is completed."</i></p>	05/10/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>an annual basis..."</p> <p>b. in "Attachment A", it reads "Mandatory Education Programs for Hospital Associates": with "Fire Safety" listed first in the list of mandatory education topics</p> <p>2. at 9:10 AM and 1:10 PM on 4/18/12, review of personnel files indicated:</p> <p>a. staff member P2 had no documented infection control or fire and life safety annual mandatory education documentation in their employee file since 2009</p> <p>b. staff members P3 and P8 were lacking documentation of mandatory infection control education for 2011, or so far in 2012</p> <p>c. staff members P11 and P12 were lacking documentation of mandatory infection control and fire/life safety education for 2011, or so far in 2012</p> <p>3. interview with staff member #53 at 4:45 PM on 4/18/12 indicated:</p> <p>a. staff members P2, P3, P8, P11, and P12 were lacking annual education as stated in 2. above</p> <p>b. the department managers are supposed to ensure annual mandatory training and education at the time of annual performance evaluations</p> <p>c. if staff members have not completed their mandatory education, they are not</p>		<p>The revised policy was communicated at the April 26 th Managers Forum and a memo was distributed on 5/9/2012 to all associates regarding the additional discipline to be taken for not completing annual mandatory training. The Human Resource Manager audited the records in the electronic system (SEED) used to administer the mandatory web-based-training (WBTs) and notified managers of any associate that had not completed their mandatory WBTs to date so that all mandatory training for 2012 could be completed and documented. The Manager of Human Resources will conduct an annual audit to ensure that documentation is present in each associate personnel file that the mandatory training and education was completed by each associate. Managers are responsible for ensuring that mandatory training and education is completed at the time of annual performance evaluations. The Human Resources Manager is responsible for reporting at least annually to the Operating Board compliance with the completion of annual mandatory education and training.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036
---------------------------------------------------------------	--------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>eligible for merit increases, but other discipline has not occurred</p> <p>d. this staff member inadvertently left Infection Control training off of Attachment A in the policy listed in 1. above, but it is a mandatory annual education expectation</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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. Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competency for all health care workers who provide direct patient care.</p> <p>Findings:</p> <p>1. The Medical Staff Bylaws (approved 8-11) and the policy/procedure Basic Life Support (CPR) Competence (approved 8-11) indicated the following: "All applicants to the Medical Staff requesting Active ED, Courtesy ED or Consulting ED privileges shall provide evidence of current CPR certification ..." The bylaws failed to require CPR competency for all</p>	S0318	<p>It is the policy of St. Vincent Mercy Hospital that in every case where a person is found without respiration or heartbeat a physician qualified to administer CPR will be available to render care.</p> <p>In the first thirty (30) days from notification of the deficiency, an amendment to the Medical Staff Bylaws was written clearly stating the requirement for physicians to demonstrate CPR competence in accordance with current standards of practice for physicians who provide direct patient care. The Medical Executive Committee (MEC) reviewed and approved the draft amendment at its May 3, 2012</p>	06/08/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>medical staff who provide direct patient care.</p> <p>2. During an interview on 4-17-12 at 1145 hours, staff A8 confirmed that the bylaws and policy/procedure failed to require CPR certification for all medical staff who provide direct patient care.</p>		<p>meeting. The first reading and approval of the amendment was completed on May 11, 2012.</p> <p>It takes two (2) readings of a bylaws amendment for ratification, therefore in the next 30 days, the second reading and approval of the CPR amendment is scheduled for June 8, 2012 and will be completed. Since the medical staff process for amending its bylaws precludes completion within thirty (30) days, an incremental thirty day phase was followed in this plan of correction.</p> <p>100% of Code Blues are reviewed providing data for peer review and performance improvement activities. The MEC, serving as the Medical Staff Peer Review committee, monitors the outcomes and findings from these reviews. Current CPR competence as defined in the amendment is monitored by the Chief Medical Officer (CMO). The CMO directs of the Office of Medical Affairs and is responsible for ongoing compliance and for reporting compliance to the hospital's operating Board.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, observation, and interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 6 contracted services.</p> <p>Findings:</p> <p>1. The St Vincent Mercy Hospital list of contracted services failed to indicate a service provider for elevators, fire sprinkler certification, emergency generator, and medical physics calibration. The list of services failed to indicate an update since 10-2011 and failed to indicate the current pest control service SP 1 or document disposal service by SP 2.</p> <p>2. Review of facility documentation indicated the following: elevator service was provided by SP 3, fire sprinkler service by SP 4, emergency generator</p>	S0394	The six (6) service providers not on the list of contracted services at the time of survey were added to the multi-page document. In addition, the scope and nature of the six services was delineated along with two or more quality standards for each, their evaluation frequency, and thresholds for review. A policy addressing the process for maintaining the list of all contracted services or those delivered by arrangements was developed and implemented to assure the following: services are provided safely and effectively, approved according to organizational policies, to ensure oversight is provided, to designate responsible person, and to comply with state and federal regulations and accreditation requirements. Appropriate quality and operational indicators and monitoring frequencies have been established for each service. The	05/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>service by SP 5, medical physics calibration by SP 6, and current pest control service by SP 1.</p> <p>3. During a tour of the facility on 4-17-12 at 1610 hours, document disposal containers provided by SP 2 were observed in the copy machine room of the administrative offices.</p> <p>4. During an interview on 4-18-12 at 0950 hours, staff A8 confirmed that the list of contracted services had not been maintained and lacked the providers identified through facility documentation and observation.</p>		<p>reporting of performance will follow established quality structures. The hospital administrator is responsible for the quality oversight program structure and to ensure documentation which includes established medical staff committee structures as applicable for patient care contracts.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0406	<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.</p> <p>Based on document review and interview, the facility lacked an effective Quality Assurance Performance Improvement (QAPI) program that included measurable and objective standards for evaluating its services at the facility for 4 services</p> <p>Findings:</p> <p>1. The Quality Assessment Performance Improvement (QAPI) report dated October-November 2011 failed to indicate the relationship between the performance indicators and outcome standards for the services of Central Sterile, Environmental Services, Laundry, and Maintenance.</p> <p>2. During an interview on 4-18-12 at 1210 hours, staff A8 confirmed that the</p>	S0406	<p>New performance indicators for central sterile, environmental services, laundry and maintenance were developed to better indicate the relationship of these indicators to outcome standards. In addition, the new performance indicators are measurable and objective. We measure a thing to learn something about it. Measurements help us better understand a thing, how it works and how we have to work with it. Measuring maintenance, environmental services, laundry and central sterile is no different in intent. Useful measures are those that improve the service's effect on the hospital performance and those that drive good reliability-building behaviors. The indicators we use help us to understand what each service is doing, what it is achieving for the</p>	05/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	QAPI report lacked measurable and objective standards for monitoring the indicated services.		hospital and what more it can do to improve operational performance. From an organizational perspective the Patient Safety and Quality Team will be responsible for monitoring the QA/PI activities and ensuring appropriate actions are being taken. The manager of each of the four services is responsible for collecting the data and reporting through established quality structures their quality assurance data and implementing change that will result in improvement. The Director of Patient Care Services that is accountable for QA/PI activities is responsible for ensuring that performance indicators are related to outcome standards for any service or department in the hospital.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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>(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>(i) Sanitation. Based on document review and interview, the infection control (IC) program failed to ensure that the operating room (OR) housekeeping services were provided in a safe and effective manner.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Infection Control in the OR (approved 8-11) Section K Operating Room Disinfection failed to indicate infection prevention objectives (clean from high to low and least contaminated to most contaminated) when describing the process for terminal cleaning of the OR following completion of surgical procedures for the day. During an interview on 4-18-12 at 	S0592	The policy/procedure Infection Control in the OR was revised to incorporate the infection prevention objectives of cleaning from high to low and least contaminated to most contaminated. The Surgery Nurse Manager reviewed the revisions with the OR staff members and the environmental staff members that do the terminal cleaning of the OR. A check sheet is used by environmental services staff that list what is to be cleaned and in what order. The infection Control and Prevention Team approved the revisions at its 5/11/2012 meeting. The Infection Control Team will be responsible for monitoring this policy and ensuring appropriate actions are being taken. Environmental audits are done by the infection control	05/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036
---------------------------------------------------------------	--------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1330 hours, staff A7 confirmed that the policy/procedure failed to indicate a systematic process for OR cleaning from high to low and least contaminated to most contaminated areas to reduce the potential for contamination of previously-cleaned surfaces by housekeeping personnel.		nurse to audit for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0744	<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 policy and procedure review, medical record review, and staff interview, the facility failed to ensure the completeness of documentation within the medical records for 3 of 3 ED (emergency department) patient records (#1, #2, and #3), and failed to ensure completeness of the record for 1 of 3 inpatient surgery patients (#6).</p> <p>Findings:</p> <p>1. at 3:45 PM on 4/18/12, review of the policy and procedure "Documentation Guidelines", indicated:</p> <p>a. in the "Policy" statement, it reads: "In accordance with the Core Value of...Hospital maintains integrity of information and assures complete and accurate documentation..."</p> <p>b. on page 2 in the section "Guideline Statements:", it reads in item #3: "Each entry (time of actual documentation) on any chart form is calendared (month/day/year) and preceded by the 24 hour clock time."</p> <p>2. at 2:30 PM, while touring the ED,</p>	S0744	<p>The Medical Staff President addressed the findings from the ISBH survey at the May 11, 2012 medical staff meeting. Specific issues included: legibility, dating and timing of reports, signatures lacking authentication, and blanks left on forms. The newly chartered medical records audit review team will monitor for compliance and individual physicians and associates will receive feedback on failure to document clearly, legibly, and completely. Failure rates will be reported with physician specific data used in re-credentialing. Clinical staff received the same report on findings from the ISBH survey at staff meetings on May 8 and 9. Since the records reviewed belonged to patients seen on 4/18/2012, where appropriate, staff members were asked at the time of survey to complete their documentation dating and completing entries left blank on the paper forms. Clinical managers are auditing charts daily for compliance and giving immediate feedback to associates on lack of compliance. The physician Chair of the Patient Safety and Quality Committee will</p>	05/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>review of the medical records of three patients seen that day indicated:</p> <p>a. for pt. #1:</p> <p>A. on the "Emergency Physician Record" form the time seen by the physician (top left of the page) is blank and the time noting completion of the record (lower right hand portion of the page) is blank</p> <p>B. the triage date is missing on the "Emergency Nursing Record" form</p> <p>C. the time of arrival is missing on the "Aftercare Instructions" form (lower right hand corner of page)</p> <p>D. on the "Physician Order Sheet", the time of "nursing Orders" for procedures done and medications given: (EKG, Cardiac Monitoring, pulse Oximetry, Saline Lock, Zofran 4 mg IV [intravenous], Phenergan 25 mg IV, and Benadryl IV), were missing--it could not be determined at what time these were ordered and what time they were performed/administered</p> <p>E. on the "Physician Order Sheet", at the bottom of the page, the physician failed to indicate the patient's condition upon discharge</p> <p>b. for pt. #2:</p> <p>A. a complete date and time seen by the physician on the "Emergency Physician Record" form is blank and the time noting completion of the record</p>		<p>be responsible for monitoring compliance rates and demonstrating improvements on the legibility and completeness of entries in the medical record. The implementation of electronic medical records in the ED with the addition of CPOE on the inpatient unit and electronic closed-loop medication administration currently scheduled for October of 2012 should address most of the issues with legibility and incompleteness.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(lower right hand portion of the page) is blank</p> <p>B. the triage date is missing on the "Emergency Nursing Record" form</p> <p>c. for pt. #3:</p> <p>A. a complete date and time seen by the physician on the "Emergency Physician Record" form is blank and the time noting completion of the record (lower right hand portion of the page) is blank</p> <p>B. the triage date is missing on the "Emergency Nursing Record" form</p> <p>C. the time of arrival is missing on the "Aftercare Instructions" form (lower right hand corner of page)</p> <p>d. for pt. #6:</p> <p>A. on the form "Operating Room Record 1 of 2", the physician failed to write the date of their authentication of the record</p> <p>B. on the "Nursing/Anesthesia Pre-Operative Assessment" form, the "time began" and "time end" is missing at the top of the page</p> <p>C. on the "Physician/AHP (advanced health practitioner/provider) Admission History and Physical Form", the time of the physician's authentication is missing at the bottom of page 3</p> <p>3. interview with staff members #54 and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036
---------------------------------------------------------------	--------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#55, who assisted with medical record review, indicated:</p> <ul style="list-style-type: none"> a. the ED physician and nursing staff were delinquent in completing the ED form documentation b. the medical record for pt. #6 was incomplete as noted in 2. d. above c. facility policy requires physicians to place a date and time with their authentication and the physician failed to do this on the medical record for the patients as listed above 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0870	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.</p> <p>Based on document review and interview, the facility failed to indicate the professional staff authorized to receive a verbal order from a physician.</p> <p>Findings:</p> <p>1. The Policy/procedure Read-Back and Verify: Verbal/Telephone Orders and Critical Test Results (approved 8-11) failed to indicate all licensed/certified personnel authorized to receive a telephone or verbal order from a medical staff member.</p> <p>2. During an interview on 4-18-12 at 1020 hours, staff A8 confirmed that the policy/procedure failed to specify the authorized personnel who may receive a</p>	S0870	The policy/procedure <i>Read Back and Verify: Verbal/Telephone Orders and Critical Test Results</i> was revised on 5/8/2012 to list specifically the licensed/certified personnel authorized to receive a telephone or verbal order from a medical staff member. The statement " telephone/verbal orders may be received by a properly licensed/certified St.Vincent Mercy associate" was changed to "Registered nurses, registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists, and CRNAs may accept verbal orders relating to their area of practice." The policy revision was posted for clinical staff to read and sign a policy cover sheet to acknowledge review of the revised policy. The	05/11/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036
---------------------------------------------------------------	--------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	verbal or telephone order at the facility.		hospital's Pharmacy and Therapeutics Committee physician Chair is responsible for ensuring on behalf of the Medical Staff that relative to verbal and telephone physician orders that the Medical Staff enforces bylaws and rules to carry out its responsibility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0872	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(P)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the medical staff failed to ensure the implementation of its policy related to discharge summaries for 1 of 3 death records reviewed (pt. # 8).</p> <p>Findings:</p> <p>1. at 3:45 PM on 4/18/12, review of the policy and procedure "Completion of Medical Records", indicated: a. on page 2 under "Procedure", item 3., it reads: "A. Must be dictated within forty-eight (48) hours of discharge and authenticated within 30 days of discharge..."</p> <p>2. at 1:30 PM on 4/18/12, review of death patient medical records indicated: a. pt. # 8 was admitted on 12/14/11 and died on 12/17/11 and lacked the presence</p>	S0872	The President of the Medical Staff, on behalf of the Medical Executive Committee, contacted the physician of patient number eight (#8) and requested that a discharge summary be completed within 48 hours to avoid delinquent status and suspension of admitting privileges. The physician completed the discharge summary on 5/10/2012 within 24 hours of notification. It is the intent of St. Vincent Mercy Hospital to assure that all medical records comply with the appropriate regulatory guidelines. Health Information Services will perform a chart audit twenty-four to forty-eight hours following discharge. Documentation found to be incomplete or missing will be appropriately flagged for signature, completion, or dictation. A final review of the patient's medical record will occur within one to three days following	05/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	of a discharge summary 3. interview with staff member #51 at 3:45 PM on 4/18/12 indicated: a. medical records staff have researched, and there is no discharge summary for pt. #8, as the policy listed in 1. above requires		discharge. Health Information Services will place a record of this review on the chart for completion. This data will be compiled and reported to the appropriate party. All physicians and staff will be notified of any deficiencies. The Medical Executive Committee is responsible for enforcing the bylaws and rules of the Medical Staff.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0954	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(e)</p> <p>(e) Emergency equipment and emergency drugs shall be available for use on all nursing units. Based on document review, observation and interview, the facility failed to ensure that emergency equipment was available for use if needed.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Crash Carts and Pediatric Resuscitation Bags (approved 8-11) failed to indicate the emergency equipment and respiratory supplies attached to or on top of the Crash Cart. During a tour of the 3rd floor medical unit on 4-17-12 at 1610 hours, the following emergency equipment was observed on the Crash Cart: a Zoll R Series defibrillator with attached oximeter and adult and pediatric hands-free Therapy Electrodes, an Oxygen cylinder with regulator, and one adult and one pediatric Ambu - bag. Also present was a clipboard containing the document Signature Sheet for Code Cart - Pediatric Code Bag and several Code Blue record documents. During an interview on 4-18-12 at 	S0954	<p>The policy/procedure Crash Carts and Pediatric Resuscitation Bags was revised along with the appendixes. A new appendix was developed and implemented listing the emergency equipment and respiratory supplies attached to or on top of the facility crash carts. The policy changes were approved by Pharmacy and Therapeutics Committee leadership to expedite implementation. The policy revisions were reviewed with 3 rd floor associates at mandatory staff meetings held on 5/ 9/2012. The pharmacy manager will ensure that all crash carts are re-stocked as outlined in the policy and available for exchange.</p>	05/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	1130 hours, staff A8 confirmed that the policy/procedure failed to ensure that all emergency equipment and supplies were available for use with the Crash Cart if needed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1118	<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 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 observation and interview, the facility failed to ensure that no condition would be created that might result in ill effects to patients or employees related to one pantry staff refrigerator on the medical/surgical nursing unit.</p> <p>Findings:</p> <p>1. at 3:20 PM on 4/17/12, while on tour of the pantry area of the medical/surgical nursing unit in the company of staff member #51, it was observed that:</p> <p>a. the staff refrigerator was dusty/dirty on the top of the appliance</p> <p>b. the refrigerator had a dried, red, sticky substance on one of the shelves inside the refrigerator, along with crumbs and other debris on surfaces</p> <p>2. interview with staff member #51 at 3:20 PM on 4/17/12 indicated:</p> <p>a. nursing staff is responsible for the</p>	S1118	<p>A new policy/procedure for Cleaning Refrigerators was approved on 5/11/2012 by the Infection Control Committee at its regularly schedule monthly meeting. The policy/procedure incorporated infection prevention objectives of cleaning from high to low and least contaminated to most contaminated. The procedure specifies both the frequency of cleaning and where to document completion of the task. The draft policy was reviewed with 3 rd floor associates at mandatory staff meetings held on 5/ 9/2012. The Medical/Surgical Nurse Manager is responsible for assigning this duty and for ensuring the completion and documentation of refrigerator cleaning on the unit. The Nurse Manager has added this monitoring to her quality assurance for the next six (6) months. If compliance is at 100%, random inspections will be</p>	05/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>cleaning of the staff refrigerator</p> <p>b. it was unknown when the refrigerator was last cleaned as there is no documentation of cleaning on the current refrigerator temperature log sheet</p> <p>3. interview with staff member #51 at 8:15 AM on 4/18/12 indicated:</p> <p>a. the policy and procedure "Stainless Steel or Metal Cleaning" was the only policy that could be found that might include refrigerator cleaning, but the policy does not address the expectation of frequency for cleaning</p> <p>b. a review of previous month's refrigerator temperature logs indicated no cleaning of the refrigerator had been documented on those logs making it unknown the last time it had been cleaned</p> <p>c. this staff member requested that nursing staff clean the refrigerator 4/17/12 and upon checking this am, it was found that the top of the refrigerator was still dirty/dusty and staff had failed to clean the outside of the appliance</p>		<p>conducted periodically to determine ongoing compliance. If on random inspection the refrigerators are not clean, then further monitoring will be initiated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1162	<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 observation and interview, the facility failed to ensure that all mechanical equipment received preventive maintenance (PM) according to a documented maintenance schedule of appropriate frequency or per the manufacturer ' s recommendations.</p> <p>Findings:</p> <p>1. On 04-17-12 at 1000 hours, staff A1 was requested to provide documentation of preventive maintenance (PM) for a facility dishwasher, floor scrubber, and operating room lights and none was provided prior to exit.</p> <p>2. During an interview on 4-17-12 at 1430 hours, staff A16 confirmed that no</p>	S1162	<p>The facility dishwasher is over forty (40) years old. Its useful life is well past the manufacturers stated life expectancy. This is primarily due to appropriate performance assurance/preventative maintenance. However, the form to document the completion of PM on all equipment (not covered under the Bioengineer contract) was revised to better reflect the PM activities completed which includes the current leakage checks. Preventative maintenance was completed on the facility's dishwasher, floor scrubber, operating room lights, and the Wayne 170 rpm floor buffer by our maintenance staff the week of 5/7/202 and completed on or before 5/11/2012. The maintenance staff has initiated a schedule based on</p>	05/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>PM documentation for the operating room lights was available.</p> <p>3. During a tour of the facility on 4-17-12 at 1645 hours, a Wayne 170 rpm floor buffer was observed without evidence of recent inspection and testing.</p> <p>4. During an interview on 4-17-12 at 1645 hours, staff A10 confirmed that the floor scrubber was not currently receiving routine PM.</p> <p>5. During an interview on 4-18-12 at 1540 hours, staff A10 confirmed that the dietary dishwasher was not currently receiving PM.</p>		<p>the various manufacturers' recommendations on all facility equipment not covered under our Bioengineer contract to document the PM. Quality assurance indicators were established to monitor compliance with the preventative maintenance schedule and will be reported monthly through quality to the Patient Safety and Quality Committee. The Maintenance Manager is responsible for ensuring that PMs are completed and documented on all mechanical equipment not on the equipment inventory list serviced by the contracted Bioengineering firm.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1166	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</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>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.</p> <p>Based on document review and interview, the facility failed to maintain appropriate documentation of preventive maintenance (PM), repairs, and ground current leakage testing on all patient care equipment at the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 4-17-12 at 1000 hours, staff A1 was requested to provide documentation of PM including evidence of ground current leakage testing for patient care equipment in use at the hospital and none was provided prior to exit. The Medical Equipment Management Plan (approved 8-11) lacked a provision to validate performance of ground current leakage testing per State law 410 IAC 15-1.5-8(d)(2)(C). 	S1166	In the first 30 days since notification of the Internal Dispute Resolution (IDR) dated July 3, 2012, the following actions have been taken to show compliance with this deficiency. A strategy and plan for appropriate documentation of the PMs on the identified 34 pieces of equipment was completed between the hospital and its equipment management vendor (TriMedx). Appropriate documentation will demonstrate completion of ground current leakage testing. In addition, the Medical Equipment Management Plan was revised to include a provision to document the performance of ground current leakage testing as part of the PM activities. In the next 30 days, all 34 pieces of medical equipment will have a PM completed and documented using the new format that clearly indicates completion of the	09/27/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036
---------------------------------------------------------------	--------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. PM documentation provided by the clinical engineering manager A16 failed to validate performance of ground current leakage testing for 34 equipment serviced by the contracted service.</p> <p>4. During an interview on 4-17-12 at 1430 hours, staff A16 confirmed that the PM documentation failed to indicate evidence of ground current leakage testing to comply with State requirements.</p>		<p>ground leakage testing. In those cases where equipment is connected directly to an electrical source, the external current leakage will be tested and documented. As long as the test results are within the equipment manufacture's acceptable range, the equipment will receive a Pass. The Manager of Administrative Services (functions as our liaison with TriMedx) is responsible for ongoing monitoring of compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1168	<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 document review, observation and interview, the hospital failed to ensure that defibrillator inspection and testing was performed according to the manufacturer's recommendations at the facility.</p> <p>Findings:</p> <p>1. The policy/procedure Crash Carts and Pediatric Resuscitation Bags (approved 8-11) lacked the following provisions:</p> <p>A. performing a daily visual inspection of the equipment including cables, cords, and connectors</p> <p>B. checking the expiration date of any perishable items (hands-free therapy electrodes)</p> <p>C. automatic internal self-testing unless configured OFF</p> <p>D. manual defibrillator discharge testing using 30 Joules energy as indicated in the 2012 Zoll R Series Defibrillator Operators Guide for</p>	S1168	<p>The policy/procedure Crash Carts and Pediatric Resuscitation Bags was revised along with the appendixes. Two of the four appendixes were put into production after the recent purchased of new biphasic monitor defibrillators and following staff training; however, the forms were not being used consistently or correctly in all locations. One form is a check sheet for completing the daily visual inspection of equipment and cables inclusive of a code readiness test. The second form is a check sheet for correctly completing the weekly hands-free manual defibrillator discharge testing using 30 joules as per the manufacturer's recommendations. The third floor nurses were re-trained on the correct procedures to comply with the manufacturer's recommendation. The daily visual inspection and code readiness logs and the weekly hands-free manual defibrillation discharge testing log will be checked weekly</p>	05/11/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT MERCY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1331 S A ST ELWOOD, IN 46036		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>performing defibrillator checks.</p> <p>2. During a tour of the 3rd floor medical unit on 4-17-12 at 1610 hours, a Zoll R Series defibrillator was observed on the Emergency Code Cart. The document Signature Sheet For Code Cart - Pediatric Code Bag checklist located on top of the Code Cart failed to indicate a provision for daily visual equipment inspections or checking expiration dates per the Operators Guide.</p> <p>3. During an interview on 4-18-12 at 1130 hours, staff A8 confirmed that the policy/procedure and Code Cart checklists failed to ensure that the equipment was checked in accordance with manufacturer 's recommendations.</p>		<p>by the third floor Nurse Manager to ensure ongoing compliance. In addition, the logs will be collected monthly from all locations by the Quality Resource Nurse to report compliance data to the Patient Safety and Quality Committee. The Director of Patient Care and Clinical Services is responsible for implementation and ongoing compliance.</p>		