STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150126	A. BUILDING 00 B. WING	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	1201 S MAIN ST CROWN POINT, IN 46307

(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	This visit was for a State hospital licensure survey. Dates: 05/14/12 through 05/16/12 Facility Number: 005007 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 06/18/12 8/17/12/ revised due to IDR	S0000	Please note that survey became available for hospital to download on 6/19/12. Some issues experienced with response entry with regard to font issues and duplication of responses when reading POC printout. Helpdesk at ISDH aware 7/1/12.	

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

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S0322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.			
	Based on observation, facility documentation, manufacturer's literature, and interview, the governing board failed to ensure policies and procedures were in place to ensure patient safety with the use of heated supplies. Findings included: 1. During the tour of the 3rd floor medical unit at 2:25 PM on 05/14/12, accompanied by staff members #A2 and A18, a Steris Amsco warming unit was observed in the clean room. Both cabinets of the unit contained blankets and the digital read-out indicated a temperature of 129 degrees Fahrenheit (F) for the top unit and 133 degrees F. for the bottom unit. Staff member #A18 indicated the temperatures were checked, but not documented, and did not know the	S0322	New policy “Blanket and Fluid Warming Devices“ was developed by CNS for Surgical Services and D irector of Nursing Operations and approved on June 28, 2012 by VP Patient Care Services. (attachment) Unit directors will post temperature log with ranges on warmers by July 1, 2012 Unit directors/managers with blanket / IV/solution warmers will educate staff of the new policy via e-mail by June 29, 2012. Director of Nursing Operations placed order for thermometers for units that do not have digital thermometer read outs. Unit directors/managers with blanket / IV/solution warmers will place thermometers in required warmers on June 29, 2012. Article submitted by Director of Nursing Operations for the July issue of the Beacon Nursing Newsletter. Unit Directors/managers will again	07/01/2012

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	exact range recommended. 2. During the tour of the Obstetrical unit at 3:20 PM on 05/14/12, accompanied by staff members #A2. A20, and A21, a Steris Amsco warming unit was observed in the recovery area. The unit contained blankets and displayed a temperature of 117 degrees F. Another warmer, with a taped notice "Please keep top warmer 110 degrees", was observed in the post-partum area. The digital read-out indicated a temperature of 125 degrees F. for the top unit and 127 degrees F. for the bottom unit. At 3:30 PM on 05/14/12, staff member #A20 indicated the temperatures were checked, but not documented, and he/she did not know why the notice of 110 degrees was on the unit. 3. During the tour of the Neonatal Intensive Care Unit (NICU) at 3:50 PM on 05/14/12, accompanied by staff members #A2, A20, and A23, a Steris Amsco warming unit was observed with blankets in the bottom unit, but nothing in the top unit. The digital read-out indicated a temperature of 117 for the bottom unit, but nothing was displayed for the top unit. When the top unit door		re-educate new policy at July unit/department meetings Monitoring: A report of compliance with daily temperature checks of blanket warmer cabinets will be submitted to Nursing Leadership Council monthly starting August 2012 and then forwarded to Hospital Quality Council. This report shall include follow-up action by unit director for any non-compliance. Monitoring will continue for at least 6 months; If 3 consecutive months of 100% performance is accomplished, a determination will be made for reducing frequency or discontinuing reporting. Responsible Party: VP Patient Care Services	

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	was opened, the cabinet was warm and operational. Staff member #A23 indicated the temperatures were checked, but not documented, and was unaware of the top unit not displaying a temperature. 4. During the tour of the Emergency Department (ED) at 9:20 AM on 05/15/12, accompanied by staff members #A2, A31, and A32, a Steris Amsco warming unit was observed in the hallway. The unit contained blankets, but had no digital read-out or temperature monitoring device. 5. During the tour of the surgical areas at 10:15 AM on 05/15/12, accompanied by staff members #A35 and A36, two Steris Amsco warming units were observed in the Center Core. The units had digital temperature read-outs and contained blankets. Staff member #A36 provided temperature monitoring logs for the units. One log was the form for the Medication Refrigerator Temperature monitoring and listed the ranges for the refrigerators. The other log was labeled for Surgery Warmers and indicated a warmer temperature normal range of 66- 150 degrees F. Two other warming cabinets containing blankets were observed in the pre-op hall and the recovery room. These cabinets			

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	were operational, but had no digital read-out or temperature monitoring devices. A Medical Solutions Fluid Warmer was observed in the med room of the pre-op area. The digital read-out displayed a temperature of 104 degrees F. Two other fluid warmers were observed in the Center Core area and displayed temperatures of 110 degrees F. Staff member #A36 indicated the units would alarm if the temperature went too high and did not need daily monitoring. He/she also indicated the temperature of the one warmer was adjusted to 110 degrees F. because the fluid cooled so quickly. 6. At 9:00 AM on 05/15/12, the operations manager, staff member #A11, indicated there was no policy for the fluid or blanket warmers and no definite parameters for the temperature maintenance. He/she indicated the notice about 110 degrees on the warmer in OB was placed at the nurses' request. He/she also indicated he/she altered the cabinets so the temperatures could not go above 130 degrees. He/she indicated the cabinets without digital read-outs should have temperature monitoring devices placed inside.			

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	7. Review of the warming units monitoring logs from the surgery area indicated a temperature range between 142 and 150 degrees F. every day from January 2 through May 15, 2012 for warmer #2 and temperatures greater than 130 degrees for 54 of the days since January 2, 2012 for warmer #3. 8. The manufacturer's literature for the Steris Warming Cabinet indicated a temperature range of 90 to 160 degrees F. The literature did not specify an acceptable range for the blankets, but indicated, "...7. Blankets can generally be felt by hand by a qualified nurse for patient safe temperature." 9. The operator's manual for the Medical Solutions Temp 2 Fluid Warmer indicated a factory preset temperature of 104 degrees F. On the first page of the instructions in bold print was the notation, "...It is suggested that each facility should contact the fluid manufacturer to obtain the manufacturer's specifications for time and temperature for the fluids being warmed."			

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S0606	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii) (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: (viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review and personnel file review, the hospital failed to monitor the immune status of 9 of 29 health care workers related to Rubella, Rubeola, Varicella (A2, A8. A11, A17, A18, A29, A32, N8 and N12), and any transmittable food related illness or diseases for 5 of 5 food service workers (A2, A8, A11, A12, and A13). Findings included: 1. St. Anthony Medical Center Employee Health Program, last approved 12/17/2010 states, " The Employee Health Service is concerned with work-related injuries and illness, employment	S0606	Current employees: 1. All employee charts will be audited and reviewed for necessary titers. If missing, employee will be notified and titers drawn. As an additional check, as employees return to employee health for annual Fit Testing, the employee file will be reviewed to ensure compliance with all titers. 2. New Hires: Human Resources and Employee Health will coordinate the Pre-Placement Physical Examination as described in the revised policy which was approved and implemented 6/28/12. (attach) The employee health manager will monitor all Pre-Placement Physical Examinations for compliance with policy and	08/16/2012

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	physicals, annual health screening, and follow-up on occupational exposures." The Employee Health Program procedure includes immunization records of Rubella, Varicella, Mumps and Hepatitis B surface antibody. Staff member #42 reviewed personnel files and confirmed the staff members that did not have the requested reliable documentation of immunization. 2. Staff member A2 health care record did not identify the staff member was screened for Rubeola, Varicella, and Hepatitis-B. 3. Staff member A8 health care record did not identify the staff member was screened for Rubeola and Varicella. 4. Staff member A11 health care record did not identify the staff member was screened for Rubeola and Varicella. 5. Staff member A17 health care record did not identify the staff member was screened for Rubeola, Varicella, and Hepatitis-B. 6. Staff member A18 health care record did not identify the staff member was screened for Rubella, Rubeola, and Varicella.		submit monthly reports to the hospital Quality Council for 6 months. At 6 months, if 100% compliance is demonstrated for every month of the 6 month reporting period, a determination will be made by the Quality Council regarding frequency of any future reporting.HR will review all HR policies triannually. This will be added as a standing HR staff meeting agenda item for status updates.The HR Manager will review all HR policies and revise as needed. The HR Director will monitor completion.**TAG NUMBER: S606 Item 12, 13, 14, 15** The Nurse Epidemiologist, Director of HR and Director of Food Services and Employee Health began work on a process to provide information on how to report diseases that are transmissible through food for both current employees and new hires who have positions that involve working with food. All current and new hires will be informed of the process. The process will be completed by July 16All aspects of deficiency corrected by 8/16/12. The Manager of Employee Health will be responsible for monitoring and monthly reporting to the Quality Council for 6 months. If 100% compliance demonstrated, then a determination will be made by the Quality Council regarding frequency of any future reporting.	

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	7. Staff member A29 health care record did not identify the staff member was screened for Rubeola, Varicella, and Hepatitis-B. 8. Staff member A32 health care record did not identify the staff member was screened for Rubella, Rubeola, and Varicella. 9. Staff member N8 health care record did not identify the staff member was screened for Rubella, Rubeola, and Varicella. 10. Staff member N12 health care record did not identify the staff member was screened for Rubella, Rubeola, and Varicella. 11. At 2:00 PM on 5/16/2012, staff member #2 indicated the facility has 2 administrative policies last reviewed 1/2005 and 4/2007. The staff member indicated the Employee Health Administrative Policy approved 1/2005 only required evidence of immunization for Rubella. The Employee Health Administrative Policy was revised and last approved 4/2007 requires documented evidence of immunization for Rubella, Rubeola, Varicella, and Hep-B. However, neither administrative policy provided was documented being			

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	last reviewed within the previous 3 years. Staff member #2 confirmed 4 staff members A2, A18, A29, and A32 were hired after 4/2007 which contradicted the immunization requirement of the Employee Health Administrative Policy that was provided by staff member #2. 12. Indiana Code 410 IAC 7-24-120 Sec 120. (a) states "The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), of the food employee or applicant: (1) is diagnosed with an illness due to:(A) Salmonella spp.; (B) Shigella spp.; (C) Shiga toxin-producing Escherichia Coli; (D) Hepatitis A virus; or (E) Norovirus " 13. Staff members A2, A8, A11, A12, and A13 personnel records did not identify that the foodservice staff were provided information on how to report diseases that			

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	are transmittable food. 14. A 1:30 PM on 5/14/2012, staff member #7 indicated all food service staff members sign a document for HR about how to report to the facility on diseases or symptoms they might have that are transmissible through food. The staff member indicated the document is kept in each foodservice staff member's HR personnel file. 15. At 2:00 PM on 5/16/2012, staff member #2 indicated all food service staff are given a stool culture when they are hired. The staff member indicated the food employees are not required to report to the facility about their health and activities as they relate to diseases that are transmittable through food. The staff member confirmed the personnel files do not have evidence of how to report diseases that are transmittable through food.			

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S0610	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (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: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review, and staff interview, the facility failed to ensure the food storage refrigerators and freezer located in the Convenient Cafe were being monitored for temperature. Findings included: 1. Food & Nutrition Services Food Handling/Labeling/ Temperature Logs	S0610	As of 6/1/12 All perishable items are now available in vending machines. If there is a power failure, mechanical failure or other conditions that result in an internal temperature that cannot maintain temperatures at less than 45ºF for 30 minutes. Standup refrigerators chest freezer equipment will be have temperatures recorded twice daily by assigned cafeteria staff. Staff	06/28/2012

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	policy states, "All coolers and freezers are monitored and recorded daily for proper temperature control twice daily (AM? PM)." 2. The Convenient Store was toured at 9:30 AM on 5/14/2012. The Convenient Cafe sells assorted prepackaged food, drinks, and personnel care items. The store contained 1 chest freezer and 2 stand-up sliding glass door refrigerators. The stand-up refrigerators contained assorted sandwiches and drinks. None of the refrigerators and chest freezer were observed with a temperature log. 3. At 4:00 PM on 5/14/2012, staff members #9 and #10 indicated the freezer and the refrigerators located in the Convenient Cafe are not being monitored for temperatures.		members were re-educated regarding safety of monitoring food temperature. The supervisor will review logs on a weekly basis by 6/28/2012. The Director of Nutrition Services will provide monthly reports to the Quality Council for 6 months. Providing 100% compliance achieved for each of the 6 months, the Quality Council will then make a determination regarding frequency of reporting.Responsible Party: Director of Nutrition Services	

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S0674	410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(f) (f) If sufficient or suitable outside facilities are not provided by undertakers or others, the hospital shall have a morgue or a low temperature body holding room. Policies covering appropriate refrigeration requirements and length of holding bodies shall be approved by the medical staff. If autopsies are performed in the hospital, there shall be a refrigerated storage unit designed for holding bodies, along with hand washing facilities and other necessary personal hygiene facilities available. Based on documentation review, the facility failed to ensure the Morgue refrigerator was being monitored appropriately in contrast to the actual body being held in the refrigerators. Findings included: 1. Morgue Temperature Monitoring policy procedure states, "The refrigerator units located in the Morgue are to have the temperatures monitored a minimum of 4 times a year. 2. The Temperature Control Record logs for 2010, 2011, and 2012 identified the temperatures of the holding refrigerator are recorded on the temperature log once per month.	S0674	To correct the deficiency, the laboratory has updated the policy to reflect the new process where security officers will record the temperature of the morgue each day the morgue is occupied. (Policy attached) The Director of the Lab in collaboration with Nursing Administration and the Director of Security will inservice security and nursing staff regarding the change in process. The Director of Security will review the log and report results to the Quality Council on a monthly basis for 6 months. If 100% compliance is demonstrated for every month, the Quality Council will make a determination regarding frequency of continued reporting.Responsible Party: Director of Security	07/16/2012

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	3. The Morgue Body holding logs revealed the refrigerators were holding a body in them 36 days from 2/1/2012 to 5/13/2012. The temperatures were not recorded on days the refrigerators were holding bodies for pick-up. 4. American Association of Tissue Banks Evaluation of Body Holding Cooling standards references a facility's necessity to maintain accurate documentation of the body holding temperature when a body is held in the Morgue for any length of stay. The American Assoxciation of Tissue Banks set the guidelines for appropriate temperature monitoring of body holding refrigerators.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	1201 S MAIN ST CROWN POINT, IN 46307

(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
S0812	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(4)(A)(B)(C)(D)(E) (F)(G)(H)(I)(J)(K) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following: (4) Maintain a file for each member of the medical staff that includes, but is not limited to, the following: (A) A completed, signed application. (B) The date and year of completion all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A copy of the member's current Indiana license showing the date of licensure and current number or an available certified list provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the medical licensing board. (D) A copy of the member's current Indiana controlled substance registration showing the number, as applicable. (E) A copy of the member's current Drug Enforcement Agency registration showing the number,as applicable (F) Documentation of experience in the practice of medicine.			

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	(G) Documentation of specialty board certification, as applicable. (H) Category of medical staff appointment and delineation of privileges approved. (I) A signed statement to abide by the rules of the hospital. (J) Documentation of current health status as established by hospital and medical staff policy and procedure and federal and state requirements. (K) Other items specified by the hospital and medical staff. Based on document review and staff interview, the facility failed to ensure 2 of 3 Physician Assistant credential files maintained a copy of the member's current Indiana controlled substance registration and/or a copy of a current Drug Enforcement Agency registration (#43 and 44). Findings Included: 1. Allied Health Professional Physician Assistant credential files states under Scope of Practice, "Physician Assistant means a person who is functioning dependent relationship with a physician licensed by the medical Licensing Board of Indiana, and who is performing under his/her supervision a task or combination of tasks traditionally performed by the physicians." 2. Physician Assistant scope of practice	S0812	Revised privilege forms to include a request for prescriptive authority indicating the requirement for approval being documentation of current CSR and DEA certificates. Approved by Credentials on 06/18/12. Sent to MEC for approval on 07/05/12 and to the board on 07/25/12. Proposing revision to allied health procedures manual of the bylaws to include more specific verbiage regarding the requirements for prescriptive authority. Going to MEC for approval 07/05/12 and to the board on 07/25/12. (attach) The VPMA of the Medical Staff will be responsible for completion of above steps and will report completion to the Quality Council.	07/25/2012

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	gives him/her prescriptive authority. Each Physician Assistant would need an Indiana CSR and a federal DEA. 3. Staff member #43 credential files identified the PA had a State of Illinois Controlled Substance certificate and a DEA. The PA did not have an Indiana CSR.			

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S0871	410 IAC 15-1.5-5 Medical Staff 410 IAC 15-1.5-5(b)(3)(O) (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: (O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual receiving a verbal order shall date, time, and sign the verbal order in accordance with hospital policy. Authentication of a verbal order must occur within forty-eight (48) hours unless a read back and verify process described under items (i) and (ii) is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge. (i) As an alternative, hospital policy may provide for a read back and verify process for verbal orders. Any read back and verify process must require that the individual receiving the order shall immediately read back the order to the ordering physician or other responsible individual who shall immediately verify that the read back order is correct. (ii) The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. Where the read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge.			

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	Based on medical record review, policy and procedure review, and interview, the facility failed to ensure verbal/telephone orders were authenticated according to policy in 14 of 20 closed inpatient records reviewed (#N1, N2, N3, N4, N5, N6, N9, N10, N11, N12, N13, N15, N16, and N17). Findings included: 1. Medical record N1 indicated a verbal order from 12/07/11, but lacked physician authentication. The record also indicated verbal orders for nonviolent behavior restraints from 12/03/11 that were not authenticated by the physician until 12/19/11. 2. Medical record N2 indicated a telephone order from 12/01/22 that was not authenticated by the physician until 12/05/11 and a second order from 12/03/11 that was authenticated 12/07/11. 3. Medical record N3 indicated verbal transfusion orders from 01/05/12 with physician authentication on 01/12/12. 4. Medical record N4 indicated verbal transfusion orders from 02/18/12 with physician authentication on 02/21/12. The record also had verbal orders from 02/16/12 with physician authentication on	S0871	Director of Nursing Operations submitted revisions to the policy "Physician Orders: Taking Telephonic And/or Verbal Orders" to reflect change of authentication of all RVVOs must be documented within 30 days of discharge. Policy approved by Administrative Policy & Procedure Committee on June 26, 2012 (see attached policy) Recommended revisions to the Medical Staff Rules and Regulations completed June 28, 2012. This was placed on the Medical Staff – Medical Executive Committee agenda for July 5, 2012. (See attachment) Medical Staff and Nursing Staff education through 7/16/12.After our change of computer systems on August 4 th to EPIC/One Chart the nurses will only be able to choose the order mode as: verbal with read back, telephone with read back, per protocol, and ordered during downtime. They will no longer need to write RVVO. (See attached screen shot) Health Information Management will audit 30 charts/month for adherence to new time frame starting with July 1, 2012 discharges and will send monthly reports to Hospital Quality Council starting August 16, 2012 and to Physician Performance Improvement Council starting August 28, 2012. Monitoring will be ongoing. Based on results, the Quality Council will make recommendations for any	07/16/2012

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	02/23/12. 5. Medical record N5 indicated verbal orders from 12/22/11 with physician authentication on 12/30/11. 6. Medical record N6 indicated verbal orders from 12/22/11 with physician authentication on 01/03/12. 7. Medical record N9 indicated verbal orders from 03/04/12 with physician authentication on 03/07/12. 8. Medical record N10 indicated telephone orders from 02/17/12 with physician authentication on 02//20/12. 9. Medical record N11 indicated telephone orders from 03/24/12 with physician authentication on 03//28/12. 10. Medical record N12 indicated verbal orders from 12/01/11 with physician authentication on 12/08/11 and a second order from 12/03/11 that was authenticated 12/12/11. 11. Medical record N13 indicated telephone orders from 01/08/12 with physician authentication on 01//12/12 and a verbal transfer order from 01/09/12 that lacked physician authentication.		increase in sample size. Physician performance will be reported to Medical staff Office for credentialing. Responsible Party: Regional Director Health Information Management	

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	12. Medical record N15 indicated a verbal order from 11/27/11 with physician authentication on 02/24/12 and a second order from 11/30/11 that was not authenticated until 03/02/12. 13. Medical record N16 indicated a verbal order from 11/26/11 with physician authentication on 02/24/12 and a second order from 11/29/11 that was not authenticated until 02/23/12. 14. Medical record N17 indicated telephone orders from 04/23/12 with physician authentication on 04//26/12. 15. The facility policy "Taking Telephone and/or Verbal Orders", last reviewed 10/13/10, indicated, "...4. The physician must date, time and countersign all verbal/telephone orders. ...8. Verbal orders for restraints must be countersigned, dated and timed within 24 hours. 9. All other verbal orders must be countersigned, dated and timed within 48 hours." 16. At 12:30 PM on 05/16/12, staff members #A2, A3, and A39, who assisted with medical record review, confirmed the findings.			

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S0932	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. Based on medical record review, policy and procedure review, and interview, the facility failed to ensure all patients had an individualized care plan completed according to policy for 13 of 20 inpatient closed records reviewed (#N1, N3, N4, N6, N9, N10, N12, N13, N14, N17, N18, N19, and N20). Findings included: 1. The medical record for patient #N1, a 78 year old female admitted 12/03/11 for hypercalcemia, anemia, and protein malnutrition, indicated a printed care plan for "Knowledge Deficit", initiated 12/03/11, but without any goal dates or documentation of Met/Not Met. Another care plan for" Thought Processes, Altered with Restraint Non-Violent Behavior Interventions" was initiated 12/04/11 with a goal date of 12/08/11, but lacked documentation of whether or not the goal was met or revised.	S0932	The plan of care was removed from the hard covered medical record on June 19, 2012 on all nursing units and kept with the nurse to be reviewed during rounding report. The documentation of the review of the plan of care with the patient is unchanged. Article regarding the requirements of the patient's plan of care and that they need to be individualized was submitted by the Nursing Educator for the July issue of the Beacon Nursing Newsletter. The article was also sent by all unit directors via e-mail to all nurses on June 28, 2012. On June 25, 2012 the Clinical informatics Manager instructed the super users for EPIC/One Chart computer training classes regarding nursing documentation starting June 26, 2012 to include in the importance of individualization, requirements of goal setting and expected outcomes, goals met/not met. The go live date for the new computer system is August 4, 2012. The new program will allow individualization; goal	06/19/2012

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	2. The medical record for patient #N3, an 84 year old female admitted 01/05/12 for congestive heart failure, diabetes, and a foot ulcer, indicated printed care plans for "Knowledge Deficit and Unstable Blood Glucose Level", "Knowledge Deficit and Impaired Skin Integrity", and "Knowledge Deficit", but all of the forms lacked any documentation by staff. 3. The medical record for patient #N4, a 46 year old female admitted 02/16/12 for acute bilateral pulmonary embolus, indicated a printed care plan for "Knowledge Deficit" with a goal date of 2/18, but without any documentation of whether this goal was Met/Not Met or documentation of any other individual needs. 4. The medical record for patient #N6, a 32 year old female admitted 12/20/11 for induction of labor, indicated a printed care plan for "C-section Delivery", but without any goal dates or documentation of Met/Not Met. 5. The medical record for patient #N9, a 3 month old female admitted 03/02/12 for bronchiolitis and respiratory distress, indicated a printed care plan for "Knowledge Deficit and Breathing Pattern, Ineffective", but without any goal dates or documentation of Met/Not Met.		setting, modification, and desired outcomes and resolution of problems (See attachment) Starting July 1, 2012 the nursing unit directors will weekly audit a sample of plans of care on their units. A monthly report will be submitted to Nursing Leadership Council starting on August 14, 2012 and then forwarded to Hospital Quality Council. This report shall include follow-up action by unit director for any non-compliance. Monitoring will continue for at least 6 months, then a determination will be made regarding frequency of reporting. Responsible Party: VP of Patient Care Services	

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	Some of the interventions initialed by the nurse were "Explore patient's understanding of disease process and treatment plan", "Assess patient's readiness/barriers to learn", "Teach patient effective coughing and deep breathing methods", and "Assist patient to cough and deep breathe". 6. The medical record for patient #N10, a 4 month old male admitted 02/16/12 for bronchitis and bronchospasm, indicated a printed care plan for "Breathing Pattern, Ineffective", with a goal date of 02/20/12, but without any documentation of Met/Not Met. Some of the interventions initialed by the nurse were "Teach patient effective coughing and deep breathing" and "Assist patient to cough and deep breathe". 7. The medical record for patient #N12, an 28 year old female admitted 12/01/11 for periorbital cellulitis and right eye pain, indicated a printed care plan for "Knowledge Deficit" with a goal date of 12/03/11, but without any documentation of Met/Not Met. The record also contained another care plan "Knowledge Deficit and Pain", but without any goal dates or documentation of Met/Not Met. 8. The medical record for patient #N13, a 4 week old male admitted 01/08/12 for			

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	RSV (Respiratory Syncytial Virus), indicated a printed care plan for "Breathing Pattern, Ineffective", with a goal date of 01/11/12, but without any documentation of Met/Not Met. Some of the interventions initialed by the nurse were "Teach patient effective coughing and deep breathing" and "Assist patient to cough and deep breathe". The record contained another care plan "Knowledge Deficit" with a goal date of 01/11/12, but without any documentation of Met/Not Met. Two of the interventions initialed by the nurse were "Explore patient's understanding of disease process and treatment plan" and "Assess patient's readiness to learn." 9. The medical record for patient #N14, an 8 year old male admitted 01/31/12 for acute appendicitis, indicated a printed care plan for "Knowledge Deficit" with a goal date of 02/03/12, but without any documentation of Met/Not Met. 10. The medical record for patient #N17, an 76 year old male admitted 04/23/12 for sepsis, lactic acidosis, altered mental status, and gastrointestinal bleed, indicated a printed care plan for "Knowledge Deficit" with a goal date of 04/26/12, but without any documentation of Met/Not Met or specific interventions implemented.			

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	11. The medical record for patient #N18, a 4 month old female admitted 02/22/12 for bronchitis, vomiting, and diarrhea indicated a printed care plan for "Knowledge Deficit and Breathing Pattern, Ineffective" with a goal date of 02/24/12, but without any documentation of Met/Not Met. Some of the interventions initialed by the nurse were "Explore patient's understanding of disease process and treatment plan", "Assess patient's readiness/barriers to learn", "Teach patient effective coughing and deep breathing methods", and "Assist patient to cough and deep breathe". 12. The medical record for patient #N19, a 57 year old female admitted 12/06/11 for severe pharyngitis and dehydration, indicated a printed care plan for "Knowledge Deficit" initiated 12/09/11, with a goal date of 12/13/11, but without any documentation of Met/Not Met. 13. The medical record for patient #N20, a 62 year old female admitted 05/05/12 for chest pain, indicated a printed care plan for "Knowledge Deficit" with a goal date of 05/08/12, but without any documentation of Met/Not Met or specific interventions implemented. Another care plan for "Thought Processes, Altered with Restraint			

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	Non-Violent Behavior Interventions" was initiated 05/09/12, but without any goal dates or documentation of Met/Not Met. 14. The facility policy "Nursing Documentation: Plan of Care and Care Conference Notes/Recommendations", last revised 09/16/09, indicated, "...2. Within 8 hours after completing the patient's history and assessment, an appropriate nursing plan of care will be initiated for fully admitted patients." The policy continued under "Procedure for Completing the Plan of Care", "1. A Nursing Plan of Care is initiated by a Registered Nurse based on the medical diagnosis and factors related to hospitalization obtained during the initial nursing physical assessment and medical history. ...6. Goals: a. Document the care plan start date, nurse's initials and proposed goal date in the row(s) that best corresponds with the desired outcome. b. Document ongoing achievement of goals as being met/not met. Include revised dates identified as new dates to achieve goals." 15. At 12:30 PM on 05/16/12, staff members #A2, A3, and A39, who assisted with the medical record review, confirmed the findings.			

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S1022	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. Based on observation, document and policy review, and interview, the facility failed to ensure medications were stored at the appropriate temperature in the Intensive Care Unit (ICU). Findings included: 1. During the tour of the ICU at 1:15 PM on 05/14/12, accompanied by staff members #A2 and A17, a medication refrigerator was observed in Med Room A. The Medication Refrigerator Temperature Record indicated the normal range was 36 to 46 degrees Fahrenheit (F). The form indicated, "...Remove medications immediately and notify the Engineering department if temperature is outside the above normal range." The log for 2012 indicated temperatures greater than 46 degrees F. for 2 days in February, 5 days in March, and 13 days in April including 3 consecutive days of 54, 60	S1022	*1)* The ICU refrigerator temperature fluctuates because it is stored in a Pyxis tower. There is poor air circulation and nurses occasionally don't get the refrigerator door completely closed. We will correct this deficiency in two phases. *a)* 6/29/12 Phase 1 (immediate correction) implemented and completed when phase 2 implemented: *i)* Pharmacy technicians will continue to check the temperature on a daily basis. *ii)* If a temperature is found to be out of range, the technician will check to make sure the refrigerator is closed and that the temperature setting is correct. The observed temperature will be documented on a Temperature Out of Range form (attached). The temperature will be rechecked within 1 hour. If the temperature is in range, this temperature will be recorded on the permanent temperature log. If the first recheck is out of range,	07/31/2012

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	150126	A. BUILDING 00 B. WING	05/16/2012

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	and 60 degrees F. 2. The facility policy "Refrigerator & Freezer Temperature Monitoring", last reviewed 4/28/10, indicated, "...4. If the temperature of any refrigerator/freezer goes out of range, the medications will be removed and stored in another refrigerator/freezer and the Engineering Department will be notified for repair." 3. At 3:10 PM on 05/14/12, the director of pharmacy, staff member #A19, indicated the techs check the temperatures daily and were supposed to recheck if the temperatures were out of range in case the door had just been opened. If the temperatures remained out of range, the pharmacist should be notified so that medications could be removed and maintenance notified. He/she indicated there was no documentation showing the temperatures were rechecked or whether maintenance was notified. 4. At 12:10 PM on 05/15/12, the operations' manager, staff member #A11, indicated the small medication refrigerators were not repaired by maintenance, but were replaced if there were problems. He/she indicated there was no documentation to indicated the ICU refrigerator was repaired or replaced recently.		the technician will record on the Temperature out of Range form and ensure proper closure. One more recheck will occur within another 1 hour period. If in range, this temperature will be recorded on the permanent log. If out of range, the medications will be removed and maintenance called. *b)* 7/31/12: Phase 2 completion (final correction): *i)* Order and receive Pyxis Remote Manager unit. Upon arrival, remove the refrigerator from the Pyxis tower and place on the top of the auxiliary unit using the Remote Manager. This will remove the refrigerator from the closed environment as well as ensure that the refrigerator is closed tightly after each use (i.e., the Remote Manager alarms if not properly closed). *ii)* When temperatures are found to be out of range, call maintenance and remove medications from the refrigerator. *Phase 1 will be initiated 6/29/12 and completed when Phase 2 is implemented. Phase 2 will be completed by 7/31/12). The Director of Pharmacy and the Lead Pharmacy Technician will be responsible for the correction and monitoring. The new process will be audited and reported to the Quality Council for the first 6 months; at the end of 6 months the Quality Council will make a determination regarding the frequency of reporting and overall success of the equipment related*	

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			interventions.	

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S1118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation, document review and interview, the facility failed to ensure an eye-washing station located in the Main Housekeeping Room and the Generator Room and failed to ensure all areas of the hospital were maintained in a clean, safe, and sanitary condition. Findings included: 1. Engineering/ Maintenance policy identify the hospital shall comply with Life Safety Code and OSHA regulations and requirements for maintaining a safe environment. 2. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be	S1118	# 3-4.Purchase and install portable eye wash station: A portable eye wash station with 15 minutes of continuous flow at .4 gallons per minute was procured, complete with locking stand and spent water receptacle. The eye wash station was set in place in the main housekeeping storeroom, complete with eye wash wall sign on June 7, 2012. Reference attached picture of installation. The eye wash station will be permanently located in the main housekeeping storeroom. Director of Engineering/Maintenance and Operations and Maintenance Manager responsible for correction. Replace existing diesel generator batteries with maintenance free batteries. Maintenance free sealed batteries were purchased and installed replacing the existing lead acid batteries with access to test the specific gravity of the electrolyte	06/29/2012

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	provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard." 3. At 9:30 AM on 5/15/2012, the Main Housekeeping room was toured. The room stored assorted gallons of chemicals used for disinfecting, waxing, etc. The room was also storing a floor scrubber that was being charged by a battery charger. The acid from the batteries and the chemicals dispensed in the room require a 15 minute of continuous flushing of eyes with water in case of splash into someone's eyes. The room did not have an eye=washing station. 4. At 10:45 AM on 5/15/2012, the Power Plant was toured. The Power Plant was located in a building not connected to the main hospital. In the Power Plant, another room was located at one end of the building. In the room, there were 2 diesel generators. One generator had		on June 14, 2012. Please note there is a centrally located eye wash station providing 10 second or less access throughout the Power Plant. Reference attached pictures of before and after battery replacement. Standard replacement for all diesel generator batteries shall be maintenance free sealed batteries. Director of Engineering/Maintenance and Operations and Maintenance Manager responsible for correction. #5 Staff was instructed immediately following survey regarding the inappropriateness of cleaning in the clean hold as well as the necessity of removing dirty gloves immediately following cleaning procedure and before touching anything. NonInvasive Infection Control policy has been revised to address these issues (see attached).Supervisor will monitor Infection control practices and report monthly to the Quality Council for 6 months; providing 100% compliance, the Quality Council will make a determination regarding ongoing frequency of reporting.Dialysis supplies: Items removed 5/16/12; e-mail to staff; e-mail to dialysis services vendor regarding proper storage practices.#6-8. Dust removed on 5/18/12, Staff In-Service held 5/30/12. Conduct additional HIGH/LOW Dust inspection each month per area by Supervisor/Team. Monthly	

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	maintenance free batteries while the other generator operates off of 2 batteries that are checked for water levels weekly. A wall mounted eye-wash station containing 2-20 ounce bottles of saline solution was adjacent to the Generators. The 2-20 ounce bottles can only provide 5-minutes of flushing of eyes in case of acid splash from the generator that contains the 2 non-maintenance free batteries. Therefore, Generator room did not have an adequate eye-wash station to provide 15 minutes of continuous flushing of eyes. 5. During the tour of the medical unit at 2:25 PM on 05/14/12, accompanied by staff members #A2 and A18, a staff member was observed wearing gloves and cleaning a piece of equipment in the clean room. The cleaning kit of supplies was placed on top of clean linen on the uncovered linen cart. After the staff member was finished, he/she picked up the cleaning kit, left the room, pushed the button for the elevator, and pushed the		reporting for 6 months to Quality Council; at the end of 6 months, Quality Council will make determination regarding freqency of reporting of ongoing monitoring. 6.c Lifeline Stem Cell (Donor Cord Blood Services a contracted service) is in the process of ordering Cavicide wipes which are hospital approved and will be stored in the original, labeled container. Disinfectants will be monitored during infection control rounds. Educated Donor Cord Blood Services of the requirement to have disinfectants in their original containers with appropriate labeling.Infection control will follow up to make sure the appropriate disinfectant is available an will monitor for deviations from appropriate practice and include in the ongoing infection control monitoring and reporting.The deficiency was corrected June 29 th .	

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	floor button inside the elevator while wearing the soiled gloves. Two gallon jugs of Naturalyte Acid Concentrate for Bicarbonate Dialysis (for dialysis machine) were observed stored on a shelf next to packaged food items in a cabinet in the nourishment area. At 2:45 PM, staff member #A18 indicated he/she did not know why the solution was stored in that cabinet and that it should not have been there. 6. During the tour of the obstetrical area at 3:20 PM on 05/14/12, accompanied by staff members #A2 and A20, the following observations were made: A. A layer of dust on the emergency box on the infant warmer in the LDR room. B. A layer of dust on the suction wall canisters in the newborn nursery. C. A spray bottle of green solution with a handwritten label "Lifeline Stem Cell Cleaning Solution" in the soiled room. 7. During the tour of the Emergency Department at 9:20 AM on 05/15/12, accompanied by staff members #A2, A31, and A32, a coating of dust was observed on the wall suction canisters and oxygen flow meters in the individual patient rooms. 8. During the tour of the surgical			

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	department at 10:15 AM on 05/15/12, accompanied by staff members #A35 and A36, a layer of dust was observed on a piece of equipment in the center of the open heart operating room.			

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S1160	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1) (d) The equipment requirements are as follows: (1) All equipment shall be in good working order and regularly serviced and maintained. Based on document review, the facility failed to ensure the Hydrocollator M-2 daily preventive maintenance inspections are in accordance with the manufacturer's specifications. Findings included: 1. The Hydrocollator M-2 Operating Manual preventive maintenance specifies the equipment be be maintained at a temperature range of 160 and 165 degrees Fahrenheit. 2. The April 2012 Hydrocollator M-2 Temperature Log noted the hydrocollator was maintained in a temperature range of 138 and 140 degrees Fahrenheit.	S1160	Finding 1: 1. 5/14/12 Found our Hydrocollator to be set to 145 degrees when the service manual calls for 160 to 166. 2. Adjusted the temperature to meet the service manual specifications. 3. Found the thermometers to be reading off of Biomed calibrated thermometer. Ordered replacement thermometers for the Hydrocollators on 5/15/12. 4. Thermometers arrived on 6/20/12 and were placed in use 5. Biomed Technicain is responsible for the PM's on the Hydrocollators the temperature will be set between 160 degrees to 166 degrees.Finding 2: 1. 6/20/12 the thermometers were replaced. (They were on back order since 5/15/12) 2. The log sheet will now show temperatures that meet the service manual specification. Responsible Party: Manager Biomedical Services	06/20/2012

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S1168	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on observation, document and manufacturer's literature review, and interview, the facility failed to ensure the defibrillators on the medical and pediatric units were checked daily as required. Findings included: 1. During the tour of the medical and pediatric units on the third floor at 2:25 PM on 05/14/12, accompanied by staff members #A2 and A18, both an adult and pediatric crash cart were observed with Lifepak 12 Defibrillator/Monitors in place. Staff member #A18 indicated checks of the cart, supplies, and the defibrillator were performed daily. Review of the 2012 logs for the adult cart defibrillator indicated a lack of checks for 5 days in January, 8 days in February, 7 days in March, 11 days in April, and 5 days in the first half of May. Review of the 2012 logs for the pediatric cart	S1168	Unit Director on May 18, 2012 started talking to staff individually regarding crash cart check requirements. Email sent out to all Medical/Peds staff from Unit Director regarding policy of daily crash cart checks on June 26, 2012 Unit Director Medical/Peds will reeducate policy regarding checking of crash cart at Medical /Peds unit meeting on July 17, 2012. A report of compliance with daily checks of defibrillators/crash cart will be submitted by Unit Director monthly to Nursing Leadership Council starting July 10, 2012 beginning with June 1, 2012 data and then forwarded to Hospital Quality Council. This report shall include follow-up action by unit director for any non-compliance. Monitoring will continue for at least 6 months, pending 100% compliance a determination will be made to reduce frequency of monitoring or discontinue the monitor. Responsible Party: VP of Patient Care Services	06/01/2012

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	defibrillator indicated a lack of checks for 6 days in February, 14 days in March, 11 days in April, and 5 days for the first half of May. 2. The manufacturer's operating instructions for the Lifepak 12 Defibrillator/Monitor indicated a user test was to be performed daily. 3. At 11:00 AM on 05/15/12, staff member #A2 confirmed the lack of the daily required defibrillator checks on the third floor medical and pediatric units.			

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S1184	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(2) (f) The safety management program shall include, but not be limited to, the following: (2) A safety committee appointed by the chief executive officer that includes representatives from administration, patient services, and support services. Based on document review, the facility failed to ensure the previous 4 quarters of Safety Committee meetings had representation from the departments defined in the Safety Management Plan. Findings included: 1. Franciscan St. Anthony Health Crown Point Safety Management Plan states, "The Safety Committee is composed of representatives of administration, clinical services, and support services. Specific composition includes representatives from: Administration, Emergency Services, Engineering, Employee Health, Franciscan Physician Network, Human Resources, Infection Control, Nursing, Materials Management, Support Services, Radiology, Risk Management, Safety/Security." 2. The previous 4 quarters of Safety	S1184	The Safety Management Plan was revised on May 17 2012 to show more relevant representation of departments on the Safety Committee with removing Human Resources representation and the adding of Environmental Services (Support Services). Material Management and Imaging (Radiology). Letters of Safety Committee appointment were sent out to representatives of Environmental Services Department, Material Management Department and Imaging Department on June 12, 2012. Terms of appointments run through 2014. The Safety/Security Director & Safety Committee Chair, will have over site responsibility of committee representation and will ensure it follows the Safety Management Plan. Ongoing reporting occurs monthly to the Hospital Quality CouncilResponsible Party: Director of Security	06/12/2012

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	Committee Meeting minutes were reviewed with staff members #11 and #12. The committee meetings did not have representation from Human Resources, Materials Management, and Radiology.			