

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150022		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/16/2012	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 1710 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
(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			
S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005021</p> <p>Survey Date: 2/14, 2/15 & 2/16/2012</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith Medical Surveyor</p> <p>QA: claughlin 03/05/12</p>	S0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/16/2012
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 LAFAYETTE RD CRAWFORDSVILLE, IN 47933		
(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	
S0674	<p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(f)</p> <p>(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.</p> <p>Based on observation, document review, medical records and staff interview, the hospital failed to have policies, approved by the medical staff, covering appropriate refrigeration requirements for bodies held in morgue cooler.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During facility tour on 2-14-12 between 1:35 PM and 2:15 PM while accompanied by Staff Member #39, a cooler for holding bodies was noted in the morgue. A record of cooler temperatures was requested. 2. Review of policies and procedures on 2-15-12 between 9:15 AM and 10:22 AM 	S0674	<p>The policy and procedure: Death (Care of the Body Following) has been revised to reflect the process for daily temperature checks of the morgue cooler. See the attached proof of documentation (page 2) indicating the procedure. This policy has also been approved by the Medical Staff as indicated by the signature of the Chief of Staff on the policy and procedure. The Director of EVS will be responsible for ensuring the staff conduct these daily checks and complete the temperature log. See attached copy of temperature log daily checks. The Infection Control nurse will be responsible for ensuring the temperature ranges are in compliance and reported to the Infection Control Committee. This issue was</p>	02/16/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150022		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/16/2012	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 1710 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
(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>revealed the hospital did not have a policy/procedure covering appropriate refrigeration temperatures of bodies held in the morgue cooler.</p> <p>3. Review of patient records on 2-15-12 between 9:15 AM and 10:22 AM revealed the following patients had expired and were placed in the morgue, as follows:</p> <p>a. Patient #L12 was admitted on "09/06/2011" at "9:53 PM" and expired on "9/6/11" at "2201". The "Emergency Department Record" indicated the patient was discharged to the "morgue" on 9-7-11 at "0036".</p> <p>b. Patient #L13 was admitted on "07/31/2011" at "4:07 PM" and expired on "08/04/2011" at "0700". The "Nursing Discharge Report" indicated the patient was discharged to the morgue on 8-4-11 at "0901".</p> <p>4. In interview on 2-15-12 between 9:15 AM and 10:22 AM, Staff Member #1 acknowledged the above findings and indicated the following:</p> <p>a. The hospital did not have a record of morgue cooler temperatures</p> <p>b. The hospital did not have a policy/procedure to indicate appropriate refrigeration temperatures of the morgue cooler.</p>		resolved on 2/15/2012.				