

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 02/28/2013	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - CRAWFORDSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 1710 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 2/26/2013 through 2/28/2013</p> <p>Facility Number: 005021</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 03/19/13</p>	S000000					

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

TITLE

(X6) DATE

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

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, manufacturer's directions, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage and storing products appropriately.</p> <p>Findings included:</p> <p>1. During the tour of the Intensive Care Unit at 10:40 AM on 02/26/13, accompanied by staff members #A2 and A11, the following observations were made:</p> <p>A. In the medication cart drawer, 18 of 19 BD Insyte Autoguard 18 gauge catheters expired: 2 expired 02/2011, 7 expired 03/2012, 1 expired 06/2012, 5 expired 07/2012, and 3 expired 12/2012.</p> <p>B. In the TNK kit, 2 of 2 BD Insyte Autoguard 18 gauge catheters expired 06/2010, 2 of 2 BD Insyte Autoguard 20 gauge catheters expired 08/2010, and 2 of 2 Sterile IV Start Kits expired 08/2009.</p> <p>2. At 11:10 AM on 02/26/13, staff member #A11 indicated supplies were checked monthly, but there was no</p>	S000554	<p>3/1/2013 - A hospital-wide sweep for outdated supplies was conducted. Any/all outdates were removed and replaced as needed. 3/8/2013 - Light-sensitive solutions were placed in containers to prevent exposure to light. 3/22/2013 - A formal house-wide monitoring process was implemented. Each department with supplies that have expiration dates will complete the form and return to Infection Control. 3/28/2013 - Infection Control reviewed monitoring records and provided feedback to department as needed. Monitoring: Infection Control Officer and/or designee will monitor department compliance with submission of the completed forms. Infection Control Officer and/or designee will conduct random department audits of supplies looking for expired items. Noncompliance situations will be reported to the appropriate management position for further action. Responsible Party: Infection Control Officer</p>	03/28/2013			

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	<p>documentation of this.</p> <p>3. During the tour of the Behavioral Health Unit at 12:30 PM on 02/26/13, accompanied by staff members #A2 and A12, the following items were observed in the crash cart:</p> <p>A. One of one Pediatric PadPro with an expiration date of 11/2011.</p> <p>B. One of one Adult PadPro with an expiration date of 09/2012.</p> <p>C. One of one Adult Positrace pad with an expiration date of 10/2012.</p> <p>D. Two of two yellow top lab tubes with an expiration date of 10/2011.</p> <p>E. Two of two red top lab tubes with an expiration date of 11/2011.</p> <p>F. Two of two purple top lab tubes with an expiration date of 12/2011.</p> <p>G. Two of two light green top lab tubes with an expiration date of 07/2011.</p> <p>H. Two of two dark green top lab tubes with an expiration date of 12/2011.</p> <p>I. Two of two blue top lab tubes with an expiration date of 05/2011.</p> <p>J. Two of two intravenous bags of 0.9% Normal Saline with an expiration date of 1 Oct. 2012.</p> <p>K. One of one Yankauer suction tips with an expiration date of 08/2012.</p> <p>4. During the tour of the Emergency Department at 1:00 PM on 02/26/13, accompanied by staff members #A2 and</p>						

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	<p>A13, the following observations were made:</p> <p>A. One package of 3.0 Surgipro suture with an expiration date of 01/2013 (expired was written on the package), in the suture cart.</p> <p>B. One of one Emergency Cricothyrotomy Cath Set, with an expiration date of 12/2011, in the cabinet of the trauma room.</p> <p>C. In the Pediatric Cart: 1 of 1 red top microtainer expired 01/2009, 1 of 1 green top microtainer expired 07/2009, 1 of 1 lavender top microtainer expired 08/2009, and 2 of 2 endotrach stylet expired 01/2013.</p> <p>5. During the tour of CT Scan Room at 1:30 PM on 02/26/13, accompanied by staff members #A7 and A8, eighteen angiocaths were observed expired in the cabinet: one expired 09/2008, six expired 11/2008, one expired 03/2010, one expired 06/2010, one expired 12/2010, one expired 07/2011, two expired 08/2011, one expired 10/2011, one expired 12/2011, one expired 01/2012, and two expired 05/2012.</p> <p>6. During the tour of Central Supply at 1:55 PM on 02/26/13, accompanied by staff member #A17, seventeen containers of Jevity Tube Feeding were observed on an open metal shelf, exposed to light.</p>				

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	<p>The label on the containers indicated the bottles contained light sensitive nutrients and manufacturer directions were to protect the containers from light until use.</p> <p>7. During the tour of the out-patient surgical area at 12:45 PM on 02/27/13, accompanied by staff members A2, A3, and A31, two of two Abbocath T 18 gauge catheters with an expiration date of 09/2012 were observed in the malignant hypothermia kit.</p> <p>8. During the tour of the radiology room in imaging at 1:20 PM on 02/27/13, accompanied by staff members #A2, A3, and A7, an open package of Kendall Medi-trace EKG pads with an expiration date of 08/2004 was observed in the drawer.</p>				

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S000592	<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.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the disinfectant cleaner was used according to the manufacturer's instructions for the Franciscan St. Elizabeth Health Sports Therapy & Rehab offsite.</p> <p>Findings included:</p> <p>1. Opti-Cide spray cleaner/sanitizer/disinfectant indicated the disinfectant shall be sprayed on and let it stand for 2 minutes before it could be wiped off. This 2-minute kill time was to</p>	S000592	<p>3/5/2013 - All products not approved for cleaning by Infection Control were removed from the Franciscan St. Elizabeth Health Sports Therapy and Rehab facility and replaced with the approved products.3/5/2013 - Staff were trained on approved products.3/20/2013 - Infection Control met with the Franciscan St. Elizabeth Health Sports Therapy and Rehab facility director to review the cleaning processes and products. An on-site inspection by Infection Control found compliance with Infection Control guidelines.Monitoring: The Director of Franciscan St. Elizabeth Health Sports Therapy and Rehab facility will randomly monitor staff compliance with the use of the approved products.</p>	03/20/2013

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	<p>ensure the surface was properly disinfected.</p> <p>2. At 9:40 AM on 2/27/2013, staff members #22 and #23 indicated the cleaner was a new disinfectant. The spray cleaner would be sprayed onto a surface followed up within 10 seconds by wiping it off.</p>		<p>Noncompliance will be addressed via one-on-one discussions with appropriate staff. The Infection Control Officer and/or designee will conduct random audits to ensure compliance is met with use of approved disinfectant products by staff. Responsible Party: Infection Control Officer</p>		

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, staff interview and observation, the facility failed to ensure chemical Wavicide-01 solution was used according to the manufacturer's recommendations and per policy for the Radiology Department.</p> <p>Findings included:</p> <p>1. Wavicide-01 high-level disinfectant manufacture sheet requires: 1. Solution is a high level disinfectant when used according to directions at full strength and 22 C, with an immersion time of 45</p>	S000596	<p>3/1/2013 - Staff were made aware of proper Wavicide procedures. Personal Protective Equipment ensured at the location of Wavicide use. 3/28/2013 - Formal education provided to Radiology staff members on the proper use of Wavicide. Education included: review of policy, review of dating the products when opened, appropriate flush sequence, use of personal protective equipment when using the product, and how compliance would be monitored. If performance is found to be inadequate, the department manager will follow the Human Resources guidelines for addressing issues of this type. (documentation supporting PPE and Policy update attached)Monitoring:The</p>	03/28/2013			

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	<p>minutes; 2. In no case should the solution be reused longer than thirty days; Wavicide-01 solution should not be used to high level disinfect a semi-critical device when sterilization is practical; 3. Ready-to-use Wavicide-01 solution should be stored in it's original sealed container, but once opened, the container only has 30-days before it needs to be discarded; 4. Manual rinsing procedure - thoroughly rinse the semi-critical medical device by immersing it completely in three separate copies volumes of water. The amount required will depend on the device being processed. Each time should be done for a minimum of 1 minute. Always use fresh water each time this step is done; 5. Use Personal protective Equipment (PPE) when Wavicide-01 solution is used. This includes: goggles, gloves, fluid resistant gowns.</p> <p>2. Franciscan St. Elizabeth Health Radiology Wavicide policy #RA 500-01 stated, "A Wavicide log</p>		<p>Radiology Director and/or designee will monitor staff compliance on a random basis. These individuals will ensure documentation is completed on the Log Sheet and the monitoring documentation submitted to Infection Control. The Infection Control Officer and/or designee will randomly monitor compliance with the guidelines for using this product. The Infection Control Officer and/or designee will monitor for receipt of appropriate documentation indicating compliance. Responsible Party: Infection Control Officer</p>		

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	<p>sheet will be used to document when the Wavicide solution was opened and when it expires. The solution will be tested with Minimum Effective Concentration (MEC) indicators once a day in the solution, and results recorded on the Wavicide log sheet. After the expiration date, the Wavicide will automatically be replaced with a new bottle of solution, regardless of the MEC results. Wavicide bottles of solution with an expired date will be discarded by dumping the solution down the drain and flushing the drain with water. The tech will wear gloves and goggles."</p> <p>3. At 1:20 PM on 2/26/2013, staff member #8 indicated the bottle would be opened and poured into the tray for the devices that would be placed in it. The solution in the container can only be used no more than 30-days. The staff member indicated the 30-day usage is for the trays, not the open gallon container. The staff member indicated the opened gallon could</p>						

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	<p>be used until it was empty, which could exceed 30 days. The staff member rinses the probes under running water from the faucet. The staff member indicated he/she does not use goggles, gloves, and fluid resistant apron.</p> <p>4. The February Wavicide MEC Indicator Log Sheet was reviewed. Of the first 26 days of February, the MEC was not recorded on the log sheet as required by policy for thirteen days (2/1; 2/2; 2/3; 2/5; 2/6; 2/9; 2/10; 2/12; 2/16; 2/17; 2/18; 2/21 and 2/22).</p> <p>5. At 1:25 PM on 2/26/2013, the ultrasound room was inspected. The open gallon of Wavicide was observed without a date on it representing a date of when 30-day opened expiration date would be. The room had no PPE available for handling the Wavicide-01 solution.</p>						

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S000612	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on document review, observation and staff interview, the facility failed to ensure that the Laundry Department were effectively destroying microorganisms while using the washers for the Hospital's Laundry and Linen and failed to ensure the Laundry Department stored the clean linen in a sanitary manner.</p> <p>Findings included: 1. CDC guidelines for laundry services in health care facilities state, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an</p>	S000612	<p>3/6/2013 - Weekly checks of appropriate temperature ranges for the laundry were initiated. Infection Control began evaluation of all products used by the laundry. 3/21/2013 - Laundry compliance checklist was updated to include cleaning of shelving units. Fan was removed from the area. Plan is to evaluate other alternatives for cooling the area when needed. Infection control assistance will be included as part of the evaluation process. If fans are deemed the best appropriate resolution for the summer, Infection Control will be involved in the formal process for implementing and maintaining. 3/21/2013 - Review of current work flows conducted. Process changes for storage being considered. A second</p>	03/28/2013			

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	<p>effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled at a residual of 50-150 ppm during the chlorine bleach cycle."</p> <p>2. Franciscan St. Elizabeth Health Laundry policy #8600-03 (last revised and approved 11/12) states, "E1 will provide the proper cycle steps and chemical concentrations to ensure linen is properly sanitized."</p> <p>3. The chemicals, provided by E1, that were being pumped into the washers were: Tri-Star Oxy-Brite, Tri-Star Neutralizer, and Tri-Star So-Fresh. The Tri-Star Oxy-brite indicates the product was an</p>		<p>method for monitoring of water temperature from the hot water pipe to the washing machines was determined to be needed. Gauge installation on the washing devices was evaluated and expected to be implemented.3/28/2013 - New Chlorine-Bleach product began being used with the wash cycles. This product in conjunction with the water temperatures meets the laundry guidelines.3/28/2013 - Laundry Director added as a member of the Infection Control Committee. This Director will provide bi-monthly reports directly to the Committee.4/28/2013 - Temperature gauges installed on the washing machine devices. This provides a visual check of the water temperature as it enters the washing device.Monitoring:Laundry Staff will monitor water temperature at least twice daily at random intervals and document. This report will go to Infection Control monthly.Laundry Director and/or designee will monitor the required cleaning regimes for compliance and report results to Infection Control.Infection Control Officer and/or designee will monitor submission of required documentation and conduct random audits for compliance.Responsible Party:Infection Control Officer</p>		

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	<p>Oxygen Bleach which activates between 140 and 180 degrees Fahrenheit. The manufacturer's label did not specify if the chemical kills any pathogens.</p> <p>4. The Preventive Maintenance Daily Instrumental Reading for the laundry water temperature averaged for the month of November 2012 was 149 F.</p> <p>5. At 12:00 PM on 2/27/2013, staff member #27 indicated he/she did not know the temperature each cycle the washer reaches, the staff member confirmed the washers do not exceed 160 degrees Fahrenheit. The staff member indicated the hospital was relying on the expertise of the vendor that the washer was properly disinfecting the hospital's linens, mops, etc.</p> <p>6. At 2:00 PM on 2/27/2013, the E1's Territory Manager explained the procedure of the washing machine cycles. The Territory Manager indicated he/she set the washers on the chemicals to be dispensed per cycle. The washers generally operate around 135</p>			

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	<p>degrees Fahrenheit. The Territory Manager indicated the oxi-brite was an oxygen bleach and not a chlorine bleach. The oxi-brite oxygen bleach was not a disinfectant like a chlorine bleach. The Territory Manager contacted E1 to see what pathogens the oxi-brite kills during the wash cycles. The representative indicated E1's corporate office told him/her to explain to hospital staff that the chemicals that are supplied to the hospital for the industrial washers kill nothing.</p> <p>7. At 2:20 PM on 2/27/2013, staff member #29 confirmed the washers were not exceeding 160 F during the wash cycle and the chemicals provided by E1 were not killing any pathogens during the wash cycles. The staff member agreed the hospital practices of washing of laundry and linen do not comply with the CDC requirements. The staff member confirmed this by the interview of E1's representative.</p> <p>8. At 12:45 PM on 2/26/2013, the Laundry Department was toured.</p>			

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	<p>The outside department contained a clean linen storage processing room and within the clean linen processing room was also another smaller clean linen storage room. The smaller room was also utilized as a break room for the Laundry Department staff members. The small clean linen storage room was observed with uncovered linen and storage boxes with dust on them. The room was observed cluttered and was observed with dust and soiled shelving units. The larger clean linen folding room was observed with storage shelves containing unfolded linen and uncovered linen. The room contained a 30-inch pedestal fan that was observed with the fan guard soiled with lint and accumulation of dirt debris on it. The room was cluttered with assorted miscellaneous items. The room contained a coffee maker and also was observed storing personnel items of the Laundry Department Staff members on the same shelves that clean linen was</p>			

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	<p>suppose to be stored. The shelves were observed storing over 10 stacks of folded 'scrubs' that were not covered or protected.</p> <p>9. Franciscan St. Elizabeth Laundry Folding and Storage of Clean Linen policy #8600-04 (Last revised and approved 11/12) stated, "Clean linen will remain sanitary and to fold and store linen in such a manner that it will remain clean and infectious free. Linen will be folded in such a manner that it will lay in orderly stacks. Shelving is to be dusted as needed. Clean linen that is to be stored for long periods of time will be bagged and tied to ensure it stays clean".</p> <p>10. At 1:00 AM on 2/26/2013, staff member #36 indicated the clean folding processing room was storing linen that needed to be washed on the same shelving unit with clean folded linen that were uncovered. The staff member indicated the room was unorganized, dirty and needs to be maintained clean and sanitary to store clean linen in the room.</p>				

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S000754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure all patient records contained an appropriately executed Consent for Admission and Treatment and/or Procedures in 6 of 21 medical records reviewed (#N2, N11, N12, N16, N19, and N21).</p> <p>Findings included:</p> <p>1. The facility policy "Informed Consent (Authorization) Policy and Procedure", last reviewed 08/10, indicated, "3. Verbal consent is acceptable in emergencies when obtaining written consent is impractical. 4. Occasionally verbal consent by telephone is the only form of consent immediately available. Consent given by telephone must be witnessed by two (2) persons and a specific record of</p>	S000754	<p>3/5/2013 - Nursing Leadership, Patient Access Director and Patient Access Supervisor began an indepth review of the process related to obtaining Consent for Admission and Treatment and/or Procedures.3/26/2013 - Nursing Leadership and Patient Access Leadership met to review their findings.3/28/2013 - Formal education was completed for all Patient Access staff members related to legibility of witness signatures, required elements of the Consents, and the required policy/procedure for the 2nd witness of a verbal consent. Nursing staff were reminded of the proper procedure for obtaining a Consent for Procedures.Monitoring:The Patient Access Supervisor and/or desginess will conduct weekly random audits of the Consent for Admission and Treatment for compliance with proper execution</p>	03/28/2013			

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	<p>the consent and the circumstances recorded in the patient's record. ...N.</p> <p>Documentation: 1. The witness(es) documents the date and a signature on the appropriate line(s) at the bottom of the consent form according to that form's guideline."</p> <p>2. The facility policy "Authentication of the Medical Record", last reviewed 08/12, indicated, "B. Entries must be: 1. Legible and accurate 2. Complete and concise 3. Dated and the time of entry recorded."</p> <p>3. The medical record for patient #N2 indicated a "Consent for Transfusion of Blood or Blood Products", signed and witnessed on 10/07/12, but without a time in the designated space to complete the form and ensure the consent was signed prior to the procedure.</p> <p>4. The medical record for patient #N11 indicated a "General Consent/Financial Agreement" that was witnessed, dated, and timed, but had "verbal consent given" written on the patient signature line. The form lacked a second witness signature.</p> <p>5. The medical record for patient #N12 indicated a "General Consent/Financial Agreement" that was dated and timed, but had "condition" written on the form</p>		<p>of the consent form. Nursing will monitor for completion of consents related to procedures. Any non-compliance issue will be discussed one-on-one with the staff member(s) involved using the approved policies for staff performance set forth by the Human Resources department. A daily report of unsigned Consent for Admission and Treatment will be reviewed by the Patient Access Supervisor and/or designees. Working in conjunction with the appropriate Nursing leadership the consent will be obtained or appropriate documentation will be made on why the consent cannot be obtained. Responsible Party: Director of Patient Access responsible for Consent for Admission and Treatment. Chief Nursing Officer responsible for Consent for Procedures.</p>		

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	<p>and lacked any witness signatures.</p> <p>6. The medical record for patient #N16 indicated a "General Consent/Financial Agreement" that was witnessed, dated, and timed, but had "psych eval" written on the form and lacked a second witness signature. The record had another "General Consent/Financial Agreement" that had a husband's signature on the witness line, but no witness signature. The record contained a "Photograph/Videotaping Release/Consent" form signed by another person, but not dated, timed, or witnessed and with no relationship designated.</p> <p>7. The medical record for patient #N19 indicated a "General Consent/Financial Agreement" that was witnessed, dated, and timed, but had "Dx" written on the form and lacked a second witness signature.</p> <p>8. The medical record for patient #N21 indicated a "General Consent/Financial Agreement" that was witnessed, dated, and timed, but had "POA (first name and relationship) verbal consent over phone" written on the form and lacked a second witness signature.</p> <p>9. At 12:15 PM on 02/18/13, staff member #A1 confirmed the medical</p>			

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	record findings and indicated if a patient or family member were unable to sign a consent, the reason should be documented along with the signatures of two witnesses, just as verbal or telephone consents should be signed.				

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S000870	<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 policy review, medical record review, and interview, the facility failed to ensure verbal/telephone orders were written and/or authenticated by the physician according to policy for 14 of 20 closed medical records reviewed (#N2, N3, N4, N5, N6, N7, N8, N13, N14, N16, N17, N18, N19, and N20).</p> <p>Findings included:</p> <p>1. The facility policy "Verbal or Telephone Orders", last revised 01/11, indicated, "2. Requirements for verbal orders also apply to telephone orders. These orders should be infrequent, must be written immediately as well as dated, timed and signed by the person receiving the order. The person taking the order</p>	S000870	<p>3/6/2013 - Physician members of the Quality Assessment Committee were made aware of the noncompliance related to authentication of orders. 3/28/2013 - Health Information Management confirms a revived process for notification to physicians of authentication needs. Appropriate nursing personnel were engaged to assist in review of orders needing authentication and reminding those physicians conducting daily rounding. 4/6/2013 - A new electronic medical record system will begin. This system enables physicians to enter orders from any remote location, thus reducing the need for verbal/telephone orders. Authentication reminders are automated to allowed for quick notification and access for</p>	03/28/2013			

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	<p>should also read back the order, to verify its accuracy, to the practitioner. 3. Verbal and telephone orders must be reviewed, signed, dated and timed by the ordering Physician within forty-eight (48) hours. ...D. Documentation will include that orders were repeated and verified (example: R&V)."</p> <p>2. The medical record for patient #N2 indicated verbal discharge orders from the physician, written by the nurse on 10/09/12, but not electronically signed by the physician until 10/12/12.</p> <p>3. The medical record for patient #N3 indicated a verbal order from the physician, written by the nurse on 12/11/12, but not electronically signed by the physician until 12/17/12 and a telephone order, written on 12/11/12, but not electronically signed by the physician until 12/19/12.</p> <p>4. The medical record for patient #N4 indicated telephone orders from the physician, written by the nurse on 12/10/12, but not electronically signed by the physician until 12/21/12.</p> <p>5. The medical record for patient #N5 indicated verbal orders from the physician, written by the nurse on 12/12/12 and 12/13/12, but not</p>		<p>approval. Monitoring - The Health Information Management Director and/or designee will monitor the authentication process to ensure compliance. Monitoring will be assisted by daily reports once the electronic medical record is implemented. Non-compliance cases will be reviewed by the appropriate HIM and Quality Committees with action taken as indicated per the Medical Staff Bylaws. Responsible Party: Health Information Management Director</p>				

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	<p>electronically signed by the physician until 01/04/13.</p> <p>6. The medical record for patient #N6 indicated a telephone order from the physician, written by the nurse on 04/16/12, but without the R&V documentation and with no physician signature.</p> <p>7. The medical record for patient #N7 indicated a telephone order from the physician, written by the nurse on a printed order sheet, but without the R&V documentation or a date and time and with no additional physician signature. The record also had an order written by the nurse from a physician on 11/28/12, but without a verbal or telephone order designation, that wasn't electronically signed by the physician until 12/07/12.</p> <p>8. The medical record for patient #N8 indicated a telephone order from the physician, written by the nurse on 11/22/12, but not electronically signed by the physician until 11/28/12.</p> <p>9. The medical record for patient #N13 indicated telephone orders from the physician, written by the nurse on 09/29/12, but without the R&V documentation, that were electronically signed by the physician on 10/26/12.</p>						

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	<p>10. The medical record for patient #N14 indicated a telephone order from the physician, written by the nurse on 10/22/12, but not electronically signed by the physician until 10/30/12 and another telephone order from 10/22/12 that lacked any physician signature.</p> <p>11. The medical record for patient #N16 indicated printed orders that were signed by a nurse from a physician on 10/24/12, but without a verbal or telephone order designation, that weren't electronically signed by the physician until 11/27/12.</p> <p>12. The medical record for patient #N17 indicated written orders that were signed by a nurse from a physician on 09/30/12, designated as S.O., that weren't signed by the physician until 10/05/12.</p> <p>13. The medical record for patient #N18 indicated a telephone order from the physician, written by the nurse on 10/30/12, but without a verbal or telephone order designation, that wasn't electronically signed by the physician until 11/27/12. The record also indicated printed orders that were signed by a nurse from a physician on 10/23/12, but without a verbal or telephone order designation, that weren't electronically signed by the physician until 11/27/12.</p>						

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	<p>14. The medical record for patient #N19 indicated telephone orders from the physician, written by the nurse on 11/04/12, but not electronically signed by the physician until 11/20/12.</p> <p>15. The medical record for patient #N20 indicated admission orders from the physician, written by the nurse on 09/20/12, but not electronically signed by the physician until 09/27/12.</p> <p>16. At 10:45 AM on 02/27/13, the findings from medical records #N2- N8 were confirmed with staff member #A14 who navigated the EMR (Electronic Medical Record).</p> <p>17. At 12:10 PM on 02/28/13, the findings from medical records #N13- N20 were confirmed with staff member #A1 who indicated the policy was not followed regarding standing/verbal/telephone orders. He/she also confirmed S.O. was the designation for standing orders which were still under the verbal/telephone order requirements</p>			

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S001118	<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, policy and procedure review, manufacturer's directions and interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in three (3) instances, Hospital Attached Garage, Electrical/Boiler Room and Surgery Departments.</p> <p>Findings included:</p> <p>1. Franciscan St. Elizabeth Health Safety Management Plan (last reviewed 11/12) states, "The management of Franciscan Dt.</p>	S001118	<p>3/1/2013 Eye wash station mounted in Surgical decontamination area.3/1/2013 - Items removed from electrical panel area.3/4/2013 - Review of fluid and irrigation solution storage in warming devices was completed. Changes are needed to be align with current product guidelines. Collaborative analysis between Pharmacy and Nursing initiated to determine the best practice to ensure compliance.3/6/2013 - Items removed from cabinet tops to ensure height requirements made.3/11/2013 - Storage of items in the garage area removed.3/28/2013 - Evaluation by Pharmacy and Nursing completed. Final determination was to simplify the process for dating and determining non-compliance for solutions kept in warming devices. The process identified is for any fluid or irrigation solutions placed in</p>	03/28/2013	

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	<p>Elizabeth Health - Crawfordsville is ultimately responsible for safety within the organization and at all physical locations."</p> <p>2. At 12:30 PM on 2/26/2013, the hospital attached garage was toured. A suspended storage 4 X 8 foot storage shelf was located in the middle of the garage. The shelf was observed storing multiple boxes of Christmas supplies, copper tubing, and other miscellaneous items. The suspended shelving unit was approximately 8-feet off of the cement floor. The wooden shelf was bowing downward toward the floor and storage boxes on the shelf were observed falling inward into each other. The appearance of the suspended shelf was very unsecured and not safe.</p> <p>3. At 12:45 PM on 2/26/2013, the Electrical/Boiler Room was toured. The room was observed with assorted boxes of maintenance equipment, mechanical equipment,</p>		<p>warming devices to be labeled iwth two week dating. If the products are not used within these two weeks the fluids or irrigations will be discarded. 4/22/2013 - Eye wash station adequacy for timing was re-evaluated. For maximum safety the direction was for an eye wash station with continual water flow to be installed in the area.4/26/2013 - Education on the new process will have been completed with appropriate staff within the facility.4/30/2013 - Eye wash station with continual water flow anticipated to have been installed in the decon area within surgery.Monitoring:Pharmacy staff will monitor for compliance with the fluids and irrigation solutions to the new policy during monthly unit inspections. Solutions found to be in noncompliance will be removed from the warming devices, documented, and reported to the appropraite manager for further action. Staff involved with monthly safety rounds will monitor storage for appropriateness and compliance. Noncompliance issues identified will be forwarded to the appropriate manager for further action.Managers will conduct one-on-one and/or department level education as appropriate for the issue identified. Action steps will be in complaince with appropriate guidelines set forth by the Human Resources department as it</p>				

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	<p>and other miscellaneous parts lying around the room cluttering it. Cardboard boxes were leaning against high-voltage electrical boxes.</p> <p>4. At 12:50 PM on 2/26/2013, staff member #6 indicated the Electrical/Boiler room was cluttered.</p> <p>5. During the tour of the decontamination room at 1:45 PM on 02/26/13, accompanied by staff members #A15 and A16, three chemicals, Sani-Master 4, Precise Hospital Foam Cleaner, and Preserve Instrument Cleaner, were observed in the room . The labels on all of the chemicals indicated a 15 minute eye flush was the first aide treatment for any chemical splashes. No eyewash equipment or station were in the room. Staff members #A15 and A16 indicated the closest eyewash station was in the ED (Emergency Department) which was located down two hallways and doorways.</p>		<p>relates to staff performance. Responsible party: Engineering Director will be responsible for ensuring items are stored appropriately and installation of appropriate eye wash station equipment. Pharmacy Director will be responsible for ensuring items kept in warming devices are compliant.</p>		

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	<p>6. During the tour of the endo-scope processing room at 2:25 PM on 02/26/13, accompanied by staff member #A15, the chemical, Wavizyme, was observed in the room . The label on the chemical indicated a 15 minute eye flush was the first aide treatment for any chemical splashes. No eyewash equipment or station were in the room. Staff member #A15 indicated the closest eyewash station was in the ED (Emergency Department) which was located down two hallways and doorways.</p> <p>7. During the tour of the surgery department at 2:40 PM on 02/26/13, accompanied by staff member #A15, nine bottles of 0.9% Normal Saline for irrigation, labeled 08/06/13, and two bottles of Sterile Water for irrigation, labeled 08/20/13, were observed in the warming cabinet in the hallway. Staff member #A15 indicated the manufacturer's directions were to</p>						

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	<p>subtract 4 weeks from the expiration date for each week the container was in the warmer and that was how they arrived at the label date.</p> <p>8. During the tour of the out-patient surgical area at 12:45 PM on 02/27/13, accompanied by staff members #A2, A3, and A31, seven intravenous bags of Lactated Ringers Solution, labeled 03/26/13, were observed in the Amsco Warmer. Staff member #A31 indicated the manufacturer of their previous solutions (Braun) indicated the fluids could remain in the warmer for four weeks. He/she indicated sometime in late 2012, the facility switched to fluids from Hospira and now were awaiting specific instructions from them.</p> <p>9. The facility policy "Warming of Fluids to be Used for Infusion or Irrigation", last revised 11/12, indicated, "A. Fluids in Flexible IV and Irrigation Solution containers with overwrap may be maintained</p>						

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	<p>in a warm air oven at 38 degrees C. for a maximum of fourteen (14) days. B. Fluids in Flexible VisIV containers without overwrap may be maintained in a warm air oven at 38 degrees C. until the adjusted expiration date. For every week that the fluid remains in the oven, four (4) weeks should be deducted from the current expiration date. After being removed from the oven, solutions may be kept at room temperature until the revised expiration date."</p> <p>10. At 9:20 AM on 02/27/13, staff member #A15 explained the marking and dating of the irrigation fluids in the warmer and indicated the fluids were usually used quickly, but the redating would indicate the worst case scenario of how long the fluids could remain in the warmer. Staff member #A18, the pharmacy director who was present, indicated he/she would obtain manufacturer information to confirm the accuracy of their policy.</p>			

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	<p>11. Documentation from the fluid manufacturer Hospira, provided by staff member #A18, indicated, "Solutions for injection and irrigation in PVC and CR3 plastic flexible containers, in their overwraps, may be warmed at a temperature not to exceed 40 degrees C. (104 degrees F)(unless specified otherwise on the product label), and for no longer than two weeks (14 days). Once the product is removed from the warming cabinet, it should be clearly labeled with a revised expiration date. The revised expiration date for the maximum time period in the 40 degrees C. warming cabinet of two weeks (14 days) is obtained by deducting eight weeks (56 days) from the original expiration date of the solution stored at 25 degrees C. (77 degrees F). If the warmed product is not used immediately, it can be returned to 25 degrees C. (77 degrees F) storage and used until the revised expiration date. Solutions should not be</p>			

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	<p>re-warmed."</p> <p>The literature continued, "Solutions for irrigation in Hospira's Aqualite plastic pour bottles, with their plastic screw cap intact and unopened, may be warmed up to 40 degrees C. (104 degrees F), and for a period of no longer than two weeks (14 days). Once taken out of the warming cabinet, it should be clearly labeled with a revised expiration date. The revised expiration date for the maximum time period in the 40 degrees C. warming cabinet of two weeks (14 days) is obtained by deducting eight weeks (56 days) from the original expiration date of the solution stored at 25 degrees C. (77 degrees F). If the warmed product is not used immediately, it can be returned to 25 degrees C. (77 degrees F) storage and used until the revised expiration date."</p> <p>12. At 11:30 AM on 02/28/13, staff member #A1 confirmed neither the practice nor the facility</p>				

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	policy followed the manufacturer directions regarding the dating and relabeling the solutions and the acceptable time for fluids to remain in the warmer.			

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S001128	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(c)(1)</p> <p>(c) In new construction, renovations, and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(1) The 2001 edition of the national "Guideline for Construction and Equipment of Hospitals and Medical Facilities" (Guidelines).</p> <p>Based on observation and staff interview, the facility failed to provide the Indiana State Department of Health (ISDH) plans of renovation of the Emergency Department.</p> <p>Findings included:</p> <p>1. At 10:30 AM on 2/27/2013, the Emergency Department was toured. The department was observed with dust partitions up where the Nurses Station had been and at the entrance of the department before you come to the patient treatment rooms. Inside the partitioned room, located where the Nurses Station had been, was a half wall not covered with wall board. New electrical wiring was observed running through the wall and the exposed ceiling. New wall board was also observed installed on some of the walls. Located in another location</p>	S001128	<p>3/6/2013 - Application for construction permit was completed and submitted to the ISDH - Health Care Engineering department.3/14/2013 - Confirmation of application being received by ISDH - Health Care Engineering. Project number: 54-13-80.Monitoring:The hospital will monitor and/or respond to information as relayed by the ISDH - Health Care Engineering department.Responsible Party:Executive Officer of the hospital.</p>	03/14/2013			

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	<p>behind partition dust walls was new plumbing dedicated for an ice machine. Adjacent to that room was a new housekeeping room.</p> <p>2. At 1:00 PM on 2:27/2013, staff member #6 indicated the hospital's architect explained to them they did not have to submit plans to ISDH for approval; therefore, staff member #6 does not have a letter of plan approval from ISDH. The staff member indicated the nurses station was being redesigned and the physicians station will be located behind the new nurses station. New electrical wiring and plumbing was done for the new locations of the nurses and physicians; and new plumbing for the new ice machine.</p>			

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S001168	<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 observation, documentation review, and staff interview, the facility failed to ensure the defibrillator was checked according to the manufacturer's instructions located in the Generations Department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Zoll-M Series operator guide indicated the defibrillator shall be discharged each shift. 2. At 12:30 PM on 2/26/2013, the Generations Department (behavioral health) was toured. The department had one Zoll-M Series defibrillator. The Daily Crash Cart Checklist on the crash cart noted the defibrillator was only 	S001168	<p>3/1/2013 - Assessment of area indicated lack of need for a Defibrillator in this unit. New process was developed for the defibrillator to be brought from the medical/surgical unit by the team responding to the emergency situation.3/28/2013 - An emergency response kit replaced the defibrillator. This eliminates the required shift-checks for this device. Staff were educated on the contents and process for checking to ensure products are not expired. Content includes equipment needed for respiratory intervention: laryngoscope, airway tubes, masks, and supplementary supplies. To ensure the crash cart arrives timely, quarterly mock codes will be implemented. Emergency medications and cart from med/surg area are readily available for the unit.Monitoring:Director of the Generations Department will conduct random audits to ensure the emergency kit is monitored for outdates appropriately.Responsible</p>	03/28/2013	

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	<p>checked once a day.</p> <p>3. At 12:40 PM on 2/26/2013, staff member #2 indicated the department operates on two shifts. The staff member confirmed the defibrillator was only checked once per day.</p>		<p>Party:Generations Unit Department Director.</p>		