

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150113		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/16/2012	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUN				STREET ADDRESS, CITY, STATE, ZIP CODE 1515 N MADISON AVE ANDERSON, IN 46011			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005100</p> <p>Survey Date: 5-14-12 to 05-16-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Cleone Peterson, BS MT (ASCP) Medical Surveyor 3</p> <p>QA: claughlin 06/21/12</p> <p>8/17/12 revised due to IDR</p>			S0000	<p>Only the Attachments were provided that support the work or the IDR that was completed. Attachments were identified using the TAG NUMBER and then what attachment A, B, C, and so forth. For S0592 the attachments were saved to a zip file and I am hopeful that this will be able to be uplinked without difficulty; however, if you have problems please contact me at: Director of Quality Resources</p>		

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

TITLE

(X6) DATE

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

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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to ensure that all policy/procedures were updated as needed and reviewed at least triennially by the responsible facility person for 5 policy/procedures reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure titled: Policy Development, Maintenance and Intranet Instructions (effective 6-03, revised 6-06 and 5-09) indicated the following: " All existing policies should be converted to the format provided as ' Attachment A ' when revised or reviewed ...title of person or committee responsible for development, revision and editing of the policy (signature also required for approval) ...policy review is conducted no less than every three (3) years ... "</p>	S0322	<p>1. A review of the present Policy titled, "Policy Development, Maintenance and intranet Instructions" (See S0322 Attachment H44) has been reviewed and revised to reflect the hospitals present handling of policy revision and review. Wording has been inserted to clarify format requirements and revision. Policy is presently slated for review and acceptance by the Vice President, Patient Care Services/CNO and Patient Safety Committee. Policy owners are to review policies cited in ISDH report for compliance to policy and if out of compliance are asked to have policies reviewed and revised in the next 90-days. Timeline is as follows: a. July 21 , 2012: Review of policy with revision and acceptance b. July 25, 2012: Policy reviewed at Patient Safety meeting and emailed to all Managers and</p>	09/20/2012			

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	<p>2. The policy/procedure Environmental Cleaning in the Surgical Practice Setting (revised 5-08) provided for review failed to indicate a signature authenticating a review/approval by the responsible person.</p> <p>3. The radiology/nuclear medicine policy/procedures Personnel Monitoring Program, Personnel Training Program, Maintaining Occupational Radiation Exposures ALARA, and Laboratory Safety Rules failed to indicate a date of review, approval, or a responsible person and failed to adopt the uniform policy/procedure format.</p> <p>4. The policy/procedure Cleaning Schedule/Procedure Medical Office Buildings Tennant Space failed to adopt the uniform policy/procedure format when reviewed on 2-04, 3-07, or 2-10 by the responsible person.</p> <p>5. During an interview on 5-16-12 at 1140 hours, staff A4 confirmed that the radiologic policy/procedures failed to indicate a date of review or approval and failed to be converted to the uniform policy format when reviewed by the responsible person in 2004, 2007, and 2010.</p>		<p>Directors c. August 20,2012: Policies cited by ISDH as out of compliance will be brought into compliance as needed according to the new approved policy. d. September 20, 2012: Outstanding policies will be reviewed, revised, and approved by owners and leadership. e. Report to QR no later than September 20, 2012. 2. Once approved, policy will be sent to all departments and staff who review and revise policies. Information has been shared via email and will be reviewed at the next Patient Safety Committee meeting July 2012. 3. Responsible party: +++Director of Quality Resources 4. Date deficiency was or will be corrected: September 20, 2012</p>				

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to ensure that contracted services were included in the Quality Assessment/ Performance Improvement Program (QAPI) program for 22 services.</p> <p>Findings:</p> <p>1. The 2011 Organizational Performance Improvement and Safety Plan (approved 5-10) lacked a provision for monitoring, evaluating, and reporting non-clinical contracted services provided at the facility.</p> <p>2. Review of program documentation failed to indicate specific and measurable indicators for monitoring and reporting the following services of anesthesia equipment maintenance, biohazardous</p>	S0406	<p>1. The Plan of Correction:a. The 2011 Organization Performance improvement and Safety Plan is a high level document that provides the "Framework for designing, measuring, assessing, and continuously improving the care and services we provide". The document directs that we identify processes and to measure the performance of services as they are initiated during the plan year. The 2013 Plan which will be revised in August (S0406 Attachment A) is presently in draft form and will be revised specifically to address the review for contracted services that impact the care and safety of patients. The document is the "what" will be done, but not the specific how it will be conducted since each contract and service is different. b. Specific Hospital and department goals are</p>	10/19/2012			

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	<p>waste removal, elevator maintenance, endoscope cleaner service, exhaust hood testing , 2 fire services, generator service, heating and air conditioning service, laser equipment and support, laundry services, medical gases, medical gas systems support, mobile lithotripsy, off-site housekeeping, pest control, radiology badge monitoring service, waste disposal, and 4 X-ray/CT/MRI equipment support services.</p> <p>3. During an interview on 5-16-12 at 1200 hours, staff A2 confirmed that the QAPI program lacked measureable and objective standards for monitoring the indicated services.</p>		<p>identified to meet the strategic plan for the hospital which includes identification and review of contracts which impacts the care and safety of patients. c. The policy on contracted services (S0406 Attachment B) was reviewed and revised. Contracts cited by ISDH surveyor will be reviewed in the next 120-days and those that do not have specific and measureable indicators shall be brought into compliance with the following Timeline for correction: i. By July 21, 2012: Contracts sited by ISDH surveyor will be reviewed to identify those that are not in compliance. ii. By August 20, 2012: (1) Define procedure for contract management and have process approved and disseminated to contract owners in house. (2) Identify specific and measureable indicators for contracts with agreed upon measures put into place with timeline on review of these measures as part of the contract review process. (3) Start process to notify contractors of the measures and work on consensus. iii. By September 19, 2012: Complete notification of contractors and finalize contracts requiring updates as necessary. Revise policy/procedure if necessary to reflect process. iv. By October 19, 2012: Complete all processes and evaluate further needs.2. To prevent the reoccurrence of the</p>		

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			<p>deficiency the following has and will be completed: a. Committee was formed in May 2012 which included identified hospital "owners" responsible for contracts. The committee has reviewed the present process and with revisions added to the contract policy and procedures. b. Biomed has added a procedure (#1467) to all contracted biomed assets in order to give better feedback to Directors. c. Contracts will be reviewed annually and reported to the Quality of Care and then to the Board. Last time contracts were reported was June ** 2012 as documented in the minutes of that meeting. 3. +++, VP of Ambulatory and Professional Services for oversight of process4. Date deficiency will be corrected: October 19, 2012.</p>	

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S0422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved; or any other information.</p> <p>(2) A potential reportable event may be</p>						

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	<p>identified by a hospital that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p>						

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	<p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2) Based on document review and interview, the facility failed to have a policy/procedure for reporting to the Indiana State Department of Health (ISDH) each reportable event determined by the quality assessment and improvement program to have occurred within the hospital.</p> <p>Findings:</p> <p>1. The policy/procedure Risk Event Entry, Medical Error Disclosure and Sentinel Events (revised 2-12) failed to indicate a process for reporting each reportable event per 410 IAC 15-1.4-2.2(a)(2).</p> <p>2. During an interview on 5-16-12 at 1310 hours, staff A6 confirmed that the policy/procedure failed to indicate the process for reporting an event to ISDH to ensure that events were reported in accordance with State requirements.</p>	S0422	<p>1. Plan of correction: a. Present policy was reviewed and revised to reflect the state and federal regulation for reporting Sentinel Events according to the Reportable events (See S0422 Attachment A) b. Revised policy must be reviewed by Patient Safety Committee for approval and then to Leadership for signature will be completed by July 29, 2012. 2. Events are reported through MIDAS and present process is to report via email or phone to the Risk manager. The Risk manager and Quality Director review events to ensure reporting in a timely manner. 3. +++ Director of Quality Resources; and +++, VP Patient Services, CNO 4. Date deficiency was or will be corrected: July 29 th once approved by Patient Safety Committee and forwarded to Leadership for signature</p>	07/29/2012			

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S0592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on document review and interview, the infection control (IC) committee failed to ensure that the operating room (OR) housekeeping services were provided in a safe and effective manner and failed to ensure that contracted housekeeping services were provided in a safe and effective manner for one outpatient off-site department.</p> <p>Findings:</p> <p>1. The policy/procedure Environmental Cleaning in the Surgical Practice Setting (approved 5-08) failed to indicate infection prevention objectives (clean from high to low and least contaminated to most contaminated) when describing the process for terminal cleaning of the</p>	S0592	<p>1. The following is the plan of correction: a. The Policy, "Environmental Cleaning in the Surgical Practice Setting" will be reviewed in the next 30-days (07/21/2012) and revised to reflect the cleaning process. Approval and education on the policy and procedure will occur by 08/20/2012. b. Policies and procedures for the cleaning of the Medical Office Buildings (S 592 Attachments and ProCare (S 592 attachment A) will be reviewed and updated by 07/21/2012. Education and approval of these policies and procedures will occur by or on 08/20/2012 c. The document "Approved Cleaning/Disinfecting Agents 2011" will be reviewed and revised by 07/21/2012 with approval and education on the</p>	08/20/2012			

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	<p>OR following completion of surgical procedures for the day.</p> <p>2. During an interview on 5-15-12 at 1400 hours, staff A7 confirmed that the policy/procedure failed to indicate a systematic process for OR cleaning from high to low and least contaminated to most contaminated areas to reduce the potential for contamination of previously-cleaned surfaces by housekeeping personnel.</p> <p>3. The policy/procedure Cleaning Schedule/Procedure Medical Office Buildings Tenant Space (approved 2-10) failed to indicate IC committee review/approval and lacked a provision for disinfecting all high touch surfaces and for using only hospital IC-approved disinfectants and cleaning products.</p> <p>4. On 5-14-12 at 1030 hours, staff A2 was requested to provide documentation indicating IC-approved cleaning products and none was provided prior to exit. The document Approved Cleaning/Disinfecting Agents 2011 failed to indicate an IC committee date of approval. On 5-15-12 at 1400 hours, staff A7 was requested to provide committee meeting documentation of cleaning and disinfecting product approval and none was provided prior to exit.</p>		<p>policy/procedure to hospital staff by or on 08/20/2012. 2. Education on the review and revision of policy and procedures has been revised with slated discussion at the next Patient Safety Committee meeting July 28 th and at the next Infection Control Meeting slated to take place on August 10, 2012. Education will be completed by 08/20/2012 3. VP of Environmental Services and Infection Control Preventionist.4. 08/20/2012 **S0592 Attachments B for Medical Office Cleaning Policies ZipFolder</p>	

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	5. On 5-15-12 at 1400 hours, staff A7 confirmed that the policy/procedures lacked the indicated provisions and approvals and confirmed that the IC program failed to ensure that housekeeping services were provided in a safe and effective manner.			
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S0596	<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 policy and procedure review, observation, document review, and staff interview, the infection control committee/practitioner failed to ensure appropriate cleaning and disinfection of toys in the Peds/Teens playroom.</p> <p>Findings: 1. at 11:00 AM on 5/16/12, review of the policy and procedure "Infection Control Policy for Peds and Teens", with a last reviewed date of 10/11, indicated: a. on page 2, it reads in section G., "Toys, high-chairs, infant safety seats,...that are shared by patients should be thoroughly cleaned and disinfected...See Toy Cleaning Policy..." 2. at 11:40 AM on 5/16/12, review of the</p>	S0596	<p>1. Plan of Correction: a. The policy and procedure, "Infection Control for Peds and Teens" will be reviewed by Infection Preventionist and Manager of the Pediatric Unit by 07/20/2012. The cleaning procedures for toys and equipment will be revised as necessary with education provided to staff responsible for these procedures. The process to document cleaning process will be reviewed and monitored for compliance by Infection Control by or on August 20, 2012. 2. Staff will review procedure for the cleaning of toys and equipment with monitoring by Infection Control for the next 90 days once monthly and if found compliant the department manager will continue to do spot checks for cleaning compliance on an</p>	08/20/2012			

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	<p>policy and procedure "Infection Control Policy for Toy Cleaning and Disinfection", with a last reviewed date of 02/10, indicated:</p> <p>a. on page one under "Text: 1. General Cleaning", it reads: "A. All toys should be examined after each use by the staff for safe construction..." and "...C. After use, all toys that have been used in patient rooms,...will be placed in a holding area for cleaning and inspection..." and "...E. Toys in playrooms or general areas should be cleaned weekly..."</p> <p>3. at 1:15 PM on 5/15/12, while on tour of the Peds/Teens nursing unit in the company of staff members #50, #56 and #61, interview of staff indicated:</p> <p>a. toys in the playroom are cleaned on a monthly basis</p> <p>4. at 1:30 PM on 5/15/12, while on tour of the Peds/Teens nursing unit in the company of staff members #50, #56 and #61, it was observed that one of the sick toddlers entered the playroom and played with several toys then exited the playroom</p> <p>5. interview with staff member #61 at 1:40 PM indicated:</p> <p>a. no staff were with the toddler while in the playroom so that they would be</p>		<p>ongoing basis. 3. Director of OB and Pediatric Services and Manger of Peditarics with monitoring oversight by Infection Control Preventionist. 4. Date deficiency was or will be corrected: Effective date 07/03/2012 with Infection Control Preventionist monitoring to be completed by 08/20/2012.</p>				

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	<p>observing which toys were handled by the coughing, sick child</p> <p>b. if toys are cleaned after being played with by a child in their hospital room, it would also be appropriate to remove and clean the toys played with by a sick child in the playroom</p> <p>c. with the staff currently only cleaning playroom toys on a monthly basis, lots of sick children could be playing with toys handled by other sick children before they are properly cleaned and disinfected</p> <p>6. at 11:40 AM on 5/16/12, review of the monthly cleaning log for the Peds/Teens nursing unit for 2012 indicated the "playroom" was cleaned on the night shift in January, February, March, and April on a monthly basis</p>			

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S0932	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on facility policy and procedure review, current patient medical record review, and staff interview, the nursing staff failed to implement the nursing care plan policy for 1 of 2 ICCU (intensive, critical care unit) patients. (pt. # 17)</p> <p>Findings:</p> <p>1. at 4:05 PM on 5/15/12, review of the policy and procedure "ICCU Scope of Assessment", with a most recent revised date of 2/2012, indicated:</p> <p>a. "...the ICU plan of Care individualizes assessment/reassessment needs, and is done on admission and every 12 hours thereafter..."</p> <p>2. while on tour of the ICCU at 3:20 PM on 5/15/12, review of open patient medical records for patients #16 and #17 indicated pt. #17 was admitted on 5/6/12 and:</p> <p>a. was lacking documentation for one 12 hour check of the nursing care plan on 5/10/12 and 5/11/12</p> <p>b. was lacking both documentations of the 12 hour checks of the nursing care plan on 5/14/12</p> <p>3. interview with staff members #50 and #60 at 3:25 PM on 5/15/12, indicated:</p> <p>a. per the facility policy, nursing staff are to reassess the patient and review/update the nursing care plan every 12 hours</p> <p>b. pt. #17 is lacking documentation of 12 hour</p>	S0932	<p>1. The following is the plan of correction for S 932: a. The policy for "ICCU Scope of Assessment" was reviewed and revised to clarify that assessments were to take place within each 12-hour shift. This clarified policy was reviewed with nursing staff prior to 06/21/2012.</p> <p>2. To prevent the deficiency from recurring in the future the nursing staff will be conducting self audits and reporting these to the ICU Director who will also be conducting spot audits for compliance. Compliance to assessments in each 12-hour shift has been added as a quality check for the annual performance for the nursing staff responsible for this function. Audits will be conducted once monthly over the next 90-days for compliance and then annually for documentation of the quality check. Deficiencies to this process will be handled 1:1 with the nursing staff involved and documented in their file. 3. +++Director of ICU 4. Date corrected 07/05/2012 Attachment: S0932 ICCU Scope</p>	07/05/2012	

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	updates, or reviews of the nursing care plan, as stated in 2. above		of Assessment		

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review Transfusion Record Review and staff interview, the facility failed to follow approved medical staff policies and procedures for the transfusion of blood for five of six patient transfusions reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of a policy titled "BLOOD AND BLOOD PRODUCTS ADMINISTRATION" labeled "Revised 2/10" on 5/14/11 between 3:00 p.m. and 4:00 p.m. revealed the following: <ol style="list-style-type: none"> <li>a. "Patients vital signs must be checked prior to obtaining blood from blood bank."</li> <li>b. "After blood has been removed from Blood Bank, the infusion must be started within 30 minutes."</li> <li>c. "A complete set of vitals must be taken 15 minutes after the infusion is initiated."</li> </ol> </li> </ol>	S0952	<ol style="list-style-type: none"> <li>1. Plan of correction for S 952: <ol style="list-style-type: none"> <li>a. Corrected on May 25, 2012 b. Added a field on the Transfusion Administration Record that allows the nurse administering the transfusion to enter directly onto the record the time that the Pre-Transfusion Vital Signs were obtained. This will clear up any confusion with the computer stamping the report with time the vitals are entered into the system as opposed to the time that the vitals were obtained. In addition, IT is working with Meditech to remedy the issue from a programming standpoint which will hopefully eliminate our need for the manual entry of the pre-transfusion vital signs time. See attachment (S0952 Blood Transfusion doc) for screen shot of revised electronic document.</li> <li>c. Transfusions that exceed the 4-hour time are reviewed 1:1 with the individual by their manager and will be re-educated at that time on the appropriate entry</li> </ol> </li> </ol>	05/25/2012			

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	<p>d. "Obtain vital signs at completion of transfusion." e. " Maximum length of infusion not to exceed 4 hours." 2. Review of 6 selected transfusions reports supplied by staff persons #7 and #8 on 5/15/12 between 10:30 a.m. and 12:30 p.m. revealed the following: a. Transfusion #1 left the blood bank at 0905 and finished 1310 exceeding the 4 hour time limit, and the pre vitals were taken at 0922 which is after the transfusion was started at 0920. b. Transfusion #2 left the blood bank at 0200 and was started at 0238 which exceeds the 30 minute limit, and had pre vitals taken at 0240 which is after the transfusion started at 0238, and had no vitals recorded at the finish of the transfusion. c. Transfusion #3 had the pre vitals taken at 0408 after the transfusion was started at 0407. d. Transfusion #4 had the pre vitals taken at 0114 which is after the transfusion was started at 0111. e. Transfusion #5 had the pre vitals taken at 0838 and was started at 0835. 3. In interview with staff person #2 and staff person #9 on 5/15/12 between 10:30 a.m. and 12:30 p.m. the surveyor was informed this seemed to be a computer timing problem which had not been previously recognized. If the pre vitals</p>		<p>process. d. The transfusion records that were reviewed by the ISDH surveyor were completed prior to our competency fair which was the week of April 23 rd . 2012. The transfusion documentation process was refined and education was provided to staff during that competency fair. It is noted that the transfusion records in May do not reflect the issue identified during the survey; however, monitoring will continue to ensure that the process is being followed by nursing staff. 2. To prevent the deficiency from recurring in the future: a. The administering nurse will enter the time that the pre-transfusion vital signs were obtained into the "Time Pre-Transfusion Vital Signs Obtained" field on the TAR. b. Competency fair April 23 rd , 2012 already provide reviewing transfusion administration competency the time limit was stressed and staff reminded of this after the ISDH survey during unit meetings the month of May and June. a. Spot audits of this process will be conducted by Quality Resources over the next 90-days and reported to the unit managers for any compliance issues. 3. Who is responsible for # 1 &amp; # 2 a. Clinical Informatics Nurses (3) and Directors of the nursing units for Medical Surgical and ICU. Quality Check: Director of Quality 4. Date deficiency was or will be corrected: a. May 25,</p>				

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	are taken before the blood is obtained from the blood bank per policy they should show a time previous to check out time from the blood bank.		2012 b. Quality check completed and reported by 08/31/2012		

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review and interview, the physical plant service failed to ensure proper ventilation in the operating rooms (OR) was safely maintained for surgical patients at the facility.</p> <p>Findings:</p> <p>1. The American Institute of Architects (2001 edition) Guidelines for Design and Construction of Hospital and Health Care Facilities indicated the following: " Table 7.2 Operating Room (OR) Minimum total air exchanges per hour : 15. "</p> <p>2. On 5-15-12 at 1615 hours, staff A9 was requested to provide documentation of Operation Room air exchange testing and certification and none was provided prior to exit.</p>	S1118	<p>1. CHA will contract with Doctors Oxygen Service, Inc. for testing air exchanges 2 times per year for 12 rooms. This will start August 2012. 2. Yearly contract with Doctors Oxygen Service Inc which will provide necessary records for tracking the air exchanges for the suites. 3. Plant OP Director 4. First test will be conducted no later than August 31 st , 2012. Future testing will be conducted approximately in March and August of each year. See Attachments S1118 A, B, &amp; C</p>	08/31/2012			

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	3. During an interview on 5-16-12 at 1510 hours, staff A9 confirmed that no testing and certification of OR air exchanges was conducted since the system was designed and constructed in 1980 and confirmed that the hospital lacked documentation of compliance with the indicated standard.			

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S1124	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.</p> <p>Based on observation, document review, and staff interview, the facility failed to ensure that staff followed the manufacturer's guidelines in the cleaning of blanket warmers in 3 (three) areas toured.</p> <p>Findings:</p> <p>1. at 11:45 AM on 5/15/12, review of the manufacturer's manual for the Getinge Warming Cabinet (used through out the facility), indicated:</p> <p>a. on page 3-3 was a picture titled: "Chamber Air Flow diagram" that shows the lower shelf with slots (called a plenum) upon which blankets are placed for warming in the cabinet</p> <p>b. on page 3-14, it states under "Maintenance and Repair": "...Regular Cleaning (every 6 months)...to clean interior surfaces thoroughly, remove the bottom plenum of the compartment...5.</p>	S1124	<p>1. Changed all warmers from annual to semi-annual PM which includes cleaning and temp check. Note that there is a warmer in the OB department but none on Peds/Teen nursing unit, this was noted in error. Warmers were cleaned as of 06/25/2012 with review of the maximum temperatures (temperature label on all warmers were replaced if missing). Staff was provided this information and cleaning schedules have been reviewed.</p> <p>2. Procedure generates automatically at six month intervals on appropriate equipment. 3. Director</p>	06/25/2012			

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	<p>Model 5524 and Models 5618, 5624 Upper Compartment: Clean under the plenums as follows. Remove the plenum..."</p> <p>2. while on tour of the PACU (post anesthesia care unit) at 10:10 AM on 5/15/12; the 4 East Ortho nursing unit at 10:50 AM on 5/15/12, and the Peds/Teens nursing unit at 1:15 PM on 5/15/12, in the company of staff members #50 and #56, it was observed that the plenum shelf, in the top of the Getinge blanket warmers, when lifted up was extremely dusty beneath the shelf</p> <p>3. interview with staff member #50 at 4:15 PM on 5/15/12, indicated:</p> <p>a. nursing staff are cleaning the blanket warmers on a monthly basis, but are not removing the plenum and cleaning the built up dust that accumulates there</p> <p>b. it was unknown that the Getinge manual recommended a 6 month cleaning under the plenum shelf</p> <p>c. there is no policy/procedure related to the blanket warmers, maximum temperature for the appliances, temperature checks, and warmer cleaning related to the dust accumulation under the plenum</p> <p>4. interview with staff members #58 at 4:30 PM on 5/15/12, indicated:</p> <p>a. neither bio-med, nor physical plant staff, are cleaning the blanket warmers as recommended by the manufacturer</p> <p>b. it was unknown that the Getinge manual recommended a 6 month cleaning under the plenum shelf</p> <p>c. there is no policy/procedure related to the blanket warmers, maximum temperature for the appliances, temperature checks, and warmer cleaning related to the dust accumulation under the plenum</p>		Biomedical Dept. 4. Deficiency was corrected on 06/25/2012	

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S1160	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on observation and interview, the facility failed to regularly service and maintain its equipment in good working order for 1 housekeeping floor buffer observed on tour.</p> <p>Findings:</p> <p>1. During a tour on 5-15-12 at 1245 hours, the following condition was observed: A 170 rpm electric floor buffer with a broken electrical grounding pin in the area for housekeeping floor equipment storage.</p> <p>2. During an interview on 5-15-12 at 1245 hours, staff A9 confirmed that the floor buffer lacked a grounding pin and was removed from service.</p>	S1160	<p>1. The electric floor buffer was removed from service on the date of the survey 05/15/2012 and was repaired by 07/02/2012. See attached completed work order (S1160 Attachment A ). 2. Staff members are reminded to check for proper functioning of equipment and to visually check electrical cords for damage or missing prongs. (S1160 Attachment B Sample Education)</p> <p>3. VP of Integrated Services and Director and Manager of Plant OP4. 07/02/2012</p>	07/02/2012	

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on observation and interview, the facility failed to ensure that all equipment had evidence of preventive maintenance ensuring a safe environment for patients in 2 locations of one department.</p> <p>Findings:</p> <p>1. During a tour of the inpatient physical therapy department on 5-15-12 at 1200 hours, the following was observed: a wooden stair steps without evidence of periodic inspection and maintenance.</p> <p>2. During a tour of the outpatient physical therapy department on 5-16-12 at 0920 hours, the following was observed: 10 wooden therapy tables without evidence of periodic inspection and maintenance.</p> <p>3. During an interview on 5-16-12 at</p>	S1164	<p>1. To correct the deficiency cited the following was done: a. The policy and procedure titled, "Preventive Maintenance/Cleaning Schedule" effective 02/1997 was updated 06/27/2012 to do monthly visual check to ensure equipment is in proper functioning for handrails and steps for stairs. Wooden tables will be inspected monthly for condition (no splintering) and stability. (S1164 Attachments A &amp; B) b. Education to staff and will enact process starting 07/01/2012. 2. To prevent the deficiency from recurring in the future: a. The monitoring schedule will be reviewed monthly for compliance by responsible staff with oversight by the Manger and/or Director of Rehab. 3. Director of Rehab. 4. Date deficiency was corrected: 07/02/2012</p>	07/02/2012			

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	9300 hours, staff A14 confirmed that the wooden therapy equipment was not receiving preventive maintenance to ensure safe use by patients and hospital personnel.			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150113		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/16/2012	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUN				STREET ADDRESS, CITY, STATE, ZIP CODE 1515 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the facility policy/procedure failed to ensure that defibrillator inspection and testing was performed as recommended by the manufacturer and failed to ensure that the equipment was properly maintained and available for use if needed.</p> <p>Findings:</p> <p>1. The Phillips M4735A HeartStart XL Defibrillator/Monitor (2007) Instructions for Use indicated the following: " perform a Shift/System Check ...along with visual inspection of the device and all cables, controls, accessories and supplies. Also regularly check expiration dates of all supplies, such as multifunction defib electrode pads ... "</p> <p>2. The policy/procedure Defibrillator</p>	S1168	<p>1. Plan of Correction includes the following: a. Crash Cart Instruction sheet was created, laminated and placed on each crash cart. Completed 06/25/2012 b. The check sheet form will be reviewed and revised as needed to reflect manufacturer's recommendation of checks. 2. To prevent deficiency from occurring in the future: a. Biomed added statement to Defib PM semi-annual procedure to confirm presence of laminated document which indicates the checks that are to be performed. b. During quarterly quality tracers the completion of defibrillator checks and verbal review of the process with responsible staff will be determined with any non-compliance identified and corrected. 3. Director of BioMed for PM and Quality Checks conducted by unit Manager/Director or Quality Resource tracer staff 4. Date deficiency was and/or will be corrected: a. June 25, 2012 all</p>	08/20/2012			

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	<p>Check (reviewed 3-10) failed to indicate the following:</p> <p>A. perform a visual inspection of the device (page 11-6)</p> <p>B. additional checks indicated on the monitor report printout (example page 11-5)</p> <p>C. additional checks per manufacturer ' s recommendations (page 11-6).</p> <p>3. During an interview on 5-15-12 at 1610 hours, staff A9 reviewed the operator ' s manual for the Phillips M4735A defibrillator and confirmed that the policy/procedure lacked the indicated provisions.</p>		<p>laminated check sheets were placed on the carts. b. Review and revise the policy for defibrillator checks with signature of Leadership on policy by 07/21/2012. c. Start education in July and complete education of new process with staff by 08/20/2012 (60-days). d. Monitor compliance to process with tracer conducted in August with results reported to unit manager/directors by no later than 08/20/2012.</p>				