

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 09/17/2014
--	---	--	---

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
--------------------	--	---------------	---	----------------------

S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 9/15/2014 through 9/17/2014</p> <p>Facility Number: 005100</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Linda Plummer, RN PH Nurse Surveyor</p> <p>Marcia Anness, RN PH Nurse Surveyor</p> <p>QA: claughlin 10/01/14</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.

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 09/17/2014
--	---	--	---

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
S000178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation and staff interview, the hospital failed to ensure the hospital license was conspicuously posted for patient and public viewing at the Community Cancer Care Radiology Oncology offsite.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 11:00 AM on 9/16/2014, the Community Cancer Care Radiology Oncology offsite was observed without a copy of the Indiana State Hospital License posted at the entrance or in the lobby of the building for the patients and visitors to view. At 11:10 AM on 9/16/2014, Offsite Administrative Director 	S000178	<p>Correction: The Administrative Director notified Administration and a copy of the hospital license was immediately obtained and placed in the lobby of the Cancer Center. To prevent the deficiency from recurring in the future--The Administration Manager will notify the VP of Integrated Services and the Directors of Plant Operations and Environmental Services and Facilities (EVS) by email that a new hospital license is available. The Administrative Manager will place a work order in the system. The Director of Environmental Services and Facilities will verify the placement at the completion of the work order. Monitoring for the presence of a current hospital license will be added to the current quarterly EVS Director's facility inspections. Responsible person: Director of Environmental Services and Facilities</p>	09/17/2014

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 09/17/2014
--	---	--	---

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
S000556	<p>staff member #27 confirmed the offsite does not have a copy of the hospital license posted for visitors to view and there was not a copy posted anywhere in the building.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the infection control committee failed to document committee approval of the 2014 Infection Control Plan.</p> <p>Findings: 1. Review of the 2/2/14 Infection Control committee meeting minutes indicated that the risk assessment was approved, but lacked any documentation that the 2014 Infection Control Plan was approved.</p>	S000556	<p>Correction: On 10/24/2014, the Infection Preventionist (IP) presented the Infection Control Plan to the Infection Prevention Committee and Physician Chairperson. This was a regularly scheduled committee meeting. To prevent the deficiency from recurring in the future: The Infection Preventionist will be responsible for annually presenting the plan for committee approval. The IP will verify that the Infection Control Plan and Infection Prevention Risk Assessment are clearly differentiated items on the agenda and meeting minutes.</p>	11/14/2014

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 09/17/2014
--	---	--	---

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
S000592	<p>2. Interview with the infection control practitioner, staff member #55, at 3:40 PM on 9/16/14, indicated that the secretary failed to document the approval of the Infection Control Plan, making it unclear that this occurred at that meeting, or at any time.</p> <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 policy and procedure review and interview, the infection control committee failed to review policies and procedures related to environmental cleaning processes of the housekeeping staff, as required by hospital rules.</p> <p>Findings: 1. Review of the policies and procedures</p>	S000592	<p>Responsible person: Infection Preventionist</p> <p>Correction: On 10/24/2014, the Infection Preventionist (IP) and Manager of Environmental Services presented the following policies and procedures to the Infection Prevention Committee and Physician Chairperson for approval and signature: Surgical Services Cleaning Schedule/Terminal Cleaning", no policy number. Supplies Used in</p>	11/14/2014

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 09/17/2014
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	
S000596	<p>"Surgical Services Cleaning Schedule/Terminal Cleaning", last revised 7/2013, with no policy number, and, "Supplies Used in E.S. (environmental services) Department", last reviewed 3/28/14, with policy number E.S./L.S. -018, indicated there was no indication on the policies that the infection control committee had evaluated and approved these policies regarding sanitation of the facility.</p> <p>2. At 9:45 AM on 9/17/14, interview with staff members #52, the vice president of integrated services (supervises housekeeping services), and #55, the infection control practitioner, indicated:</p> <p>a. At this time, the infection control committee has its own policies regarding: facility supplies used for cleaning and disinfecting; cleaning processes; sanitation; etc.</p> <p>b. Currently, the infection control committee does not review, or evaluate, E.S. policies and give approval or recommendation of these.</p> <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</p>		<p>E.S. (environmental services) Department-- policy number E.S./L.S. -018.Cleaning of Morgue E.S./L.S.-132This was a regularly scheduled committee meeting.To prevent the deficiency from recurring in the future: Environmental Service policies related to environmental cleaning processes will be presented at the Infection Prevention meetings by the Infection Preventionist and Manager of Environmental Services for approval of changes/updates. Policies will undergo committee review triennially or as needed to incorporate updates. Approval for policies will be clearly differentiated in the meeting minutes.Responsible person: Infection Preventionist</p>		

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 09/17/2014
--	---	--	---

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
	<p>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 and interview, the infection control committee failed to document clearly their review, and evaluation, of biologicals and sterilization processes, as required by hospital rules.</p> <p>Findings:</p> <p>1. Review of the infection control committee meeting minutes indicated: a. The August 16, 2013 meeting had a report that indicated: "5. Biological Reports - No + biologicals reported". b. The October 18, 2013, February 2, 2014, April 18, 2014, and June 20, 2014 meeting minutes read: "5. Biological Reports - Nothing reported at this meeting".</p> <p>2. At 9:45 AM on 9/17/14, interview with staff member #55, the infection control practitioner, indicated: a. The secretary for the infection</p>	S000596	<p>Correction: The Infection Preventionist (IP) resubmitted and reported on completed audits of biological reports from Aug. 2013, Oct. 2013, Feb. 2014, April 2014 and June 2014 to the Infection Prevention Committee meeting on 10/24/2014. The inclusion/approval of this information was clearly differentiated in the meeting minutes. To prevent the deficiency from recurring in the future: Meeting minutes will include a statement reflecting: "No negative biological reports identified and in need of reporting to the committee." The IP provided a reminder to the committee members for the need to be very specific with this language in the minutes. Responsible person: Infection Preventionist</p>	11/14/2014

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 09/17/2014
--	---	--	---

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
S000612	<p>control committee has changed the way reporting of biologicals and sterilization reports are documented.</p> <p>b. It cannot be determined, by the language in the meeting minutes, if there was nothing reported at all, or if there was a report that indicated all was OK and there was nothing negative to report.</p> <p>c. The reporting needs to be more in depth and the documentation needs to be clear.</p> <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 observation and staff interview, the hospital failed to store soiled laundry/linen in the soiled utility room of the</p>	S000612	Correction-1) The Clinical Director immediately moved the bags of soiled linen to the soiled linen hold area. 2) Education provided to staff in Radiation Oncology Department with	09/17/2014

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 09/17/2014
--	---	--	---

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
	<p>Community Cancer Care Radiology Oncology offsite.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 11:20 AM on 9/16/2014, the Community Cancer Care Radiology Oncology offsite storage room was observed storing assorted medical supplies on shelving units. The room was also observed storing 6 clear bags of linen on the floor. At 11:25 AM on 9/16/2014, Radiology Tech staff member #29 indicated the 6 bags of linen/laundry in the offsite's storage room contained soiled linen/laundry. At 11:28 AM on 9/16/2014, Offsite Administrative Director staff member #27 indicated the 6 bags of soiled linen/laundry in the offsite's medical supply's storage room should have been stored in the soiled utility room and not with clean supplies. 		<p>regards to the storing of soiled linen only in the soiled hold area. It was emphasized that soiled linen must never be placed in a storage room. 3) Audits will be conducted monthly for six months and reviewed with staff. To prevent a recurrence of this deficiency: 1) The Clinical Director met with all of the staff of the Radiation Oncology Department, including nurses, radiation techs, radiation manager, dosimetrist, physicist, and ancillary staff. The team was shown the proper location for storing soiled linen/laundry. 2) The Administrative Director addressed all oncology staff regarding removal and storage of soiled linen/laundry; noting the location of the soiled hold area. The hospital policy was reviewed with staff. 3) A follow-up audit was performed by the Administrative Director. The storage area was checked and has been periodically checked since 09/17/2014. The soiled hold area was checked to ensure the soiled linen/laundry has been stored appropriately. The deficiency was readdressed in a rounding meeting as a reminder. The staff affirmed they have continued to follow the policy. Responsible person: Administrative Director</p>	

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 09/17/2014
--	---	--	---

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
--------------------	--	---------------	---	----------------------

S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p>			
---------	---	--	--	--

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 09/17/2014	
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			
	<p>Based on policy and procedure review, medical record review, and interview, the nurse executive failed to ensure the implementation of the facility pain policy for 1 of 2 obstetric patients (pt. #3) and 1 of 2 ortho post op unit patients (pt. #9).</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Care of the Patient Experiencing Pain", policy number H222, last revised 7/12, indicated:</p> <p>a. On page 3., it reads in item 7.: "Reassessing pain level using the pain scale at intervals appropriate to the patient's condition and type of pharmacological and non-pharmacological interventions used. For any IV (intravenous) pain medications, an evaluation of the effects of medication and pain level should occur within 15 - 45 minutes and for oral medications, an evaluation should occur within 45 - 75 minutes."</p> <p>2. While on tour of the obstetrics unit, open medical records were reviewed and indicated:</p> <p>a. Pt. #3 had a c-section on 9/12/14 and had pain medication (Percocet and Anaprox) on 9/14/14, as follows:</p> <p>A. At 1:44 AM; 9:06 AM; and 4:02 PM; with all three lacking documentation of follow up reassessment for pain relief.</p>	S000912	<p>Correction: A Computer Based Learning (CBL) module, developed by the Pain Council, will be the educational source provided to staff who administer pain medications on 4E Med/Surg and OB units. Mandatory education will be completed by November 30, 2014. To prevent recurrence of this deficiency: The Clinical Managers of 4E Med/Surg and OB units will conduct monthly chart audits to verify documentation of pain re-assessments. The audits will be completed one day each month and will consist of all active patient records on the OB and 4E Med/Surg units that day. These audits will continue until a 90% accuracy rate is maintained for 6 months. Results will be reported to the VP of Patient Care Services. Responsible persons: Director of Acute Care Services; 4E Med/Surg Unit Clinical Manager; Director Women's and Children's Services; Clinical Manager of OB/Peds.</p>	12/12/2014			

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 09/17/2014
--	---	--	---

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
S001118	<p>3. At 2:40 PM on 9/15/14, interview with staff member #66, the obstetrics nurse manager, indicated:</p> <p>a. Documentation is lacking for follow up reassessment after pain medication given, as listed in 2. above, related to patient #3.</p> <p>4. While on tour of the 4 East ortho post op unit, open medical records were reviewed and indicated:</p> <p>a. Pt. #9 had surgery on 9/14/14 and had documentation as follows:</p> <p>A. Dilaudid was given at 8:57 AM on 9/14/14 for pain at a level of 8, with no documentation of follow up reassessment for pain relief.</p> <p>5. At 3:00 PM on 9/16/14, interview with staff member #62, the director of acute care services, indicated:</p> <p>a. Documentation is lacking for follow up reassessment after pain medication given, as listed in 4. above, related to patient #9.</p> <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</p>			

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 09/17/2014
--	---	--	---

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
	<p>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 documentation review and observation, the hospital failed to maintain the equipment in such a manner that the safety and well-being of staff are assured in the Boiler Room's Maintenance Shop.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The 2014 Community Hospital Anderson Safety Management Plan indicated the hospital complies with OSHA and Life Safety Code regulations and standards. OSHA standards indicated that bench mounted abrasive wheels used for external grinding shall be provided with safety guards and work rests. Safety guards shall be strong enough to withstand the effect of a bursting wheel. Work-rests shall be kept adjusted 	S001118	<p>Correction: Plant Ops has two bench grinders. With regards to finding #2, one grinder has safety shields and tool guides. The Director of Plant Operations issued a work order to adjust the guides and clean the shields. The work order was completed by staff on 09/17/2014. With regards to finding #3, the 2nd grinder did not have either of the safety devices. The Director of Plant Operations issued a work order to remove the 2nd grinder from the building and to place out of service. The 2nd grinder was removed on 09/17/2014 by staff. The Plant Operations Supervisor provided education to staff of the importance of the safety devices. Staff were reminded that the safety devices are not to be adjusted or removed. Staff signed a written memo indicating they had received and understand the education. To prevent recurrence of this deficiency: The Director of Plant Operations created a PM to inspect the grinder for shields and guides. The PM will generate monthly and will be assigned by the director to the boiler person to complete the inspection. Responsible person: Director of Plant Operations</p>	09/17/2014

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 09/17/2014
--	---	--	---

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
S001150	<p>closely to the wheel with a maximum opening of 1/8" to prevent the work from being jammed between the wheel and the rest, which may cause wheel breakage.</p> <p>3. At 1:15 PM on 9/16/2014, the Boiler Room's Maintenance Shop was observed with a bench mounted machine with two abrasive wheels which are used for external grinding. The safety guards or work-rest for both wheels were missing from the bench mounted machine.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</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>(9) All back flow prevention devices</p>			

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 09/17/2014	
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			
	<p>shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation and staff interview, the hospital failed to provide a back flow prevention device for the metal shower located in the Outpatient Therapy Department.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 11:47 AM on 9/15/2014, a bathroom located in Outpatient Therapy Department was observed with a metal shower hose shower head lying on the floor of the bath/shower stall combo. The shower was observed without a back flow prevention device. At 11:50 AM on 9/15/2014, Physical Plant staff member #15 indicated the shower hose in the Outpatient Therapy Bathroom did not have a back flow prevention device. 	S001150	<p>Correction: The Plant Operations Supervisor ordered a back flow preventer on 09/22/2014. The back flow preventer arrived on 09/24/2014 and was installed on the same day by the Plant Operations staff. To prevent recurrence of this deficiency: a back flow preventer will be ordered at the time spray hoses are ordered. Person responsible: Director of Plant Operations</p>	09/24/2014			

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 09/17/2014
--	---	--	---

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
S001166	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.</p> <p>Based on documentation review, observation and staff interview, the hospital failed to provide evidence that all clinical and non-clinical electrical equipment was tested before put into service in the hospital.</p> <p>Findings included:</p> <p>1. Initial Testing and Installation of Medical Equipment policy #H158 (Last reviewed 3/21/2013) stated, "All new medical equipment will be tested upon</p>	S001166	<p>Corrections: Findings #4,5 and 7- -On 10/17/2014, Director of Plant Operations instructed a staff member to go to ICU, test the heater, and place an inspection tag on the heater. Plant Operations staff completed that task on 10/17/2014. Director of Plant Operations updated the H136 policy to include a statement concerning any heaters found without the inspection tab should be taken out of service and a work order sent to Plant Operations. VP of Integrated services reviewed changes and signed the H136 policy on 10/22/2014. To prevent recurrence of this deficiency: Director of Plant Operations will provide education review of</p>	11/14/2014

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 09/17/2014
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	
	<p>delivery or installation to assure all performance and safety specifications are met. All portable and other non-fixed clinical equipment will be tested by Bio-Med Department at the time of delivery. Plant Operations will inspect all non-clinical electro-mechanical equipment at the time of delivery."</p> <p>2. At 1:00 PM on 9/16/2014, 4-East Post-op Unit nurse station was observed with a charging unit for a rechargeable razor. The base of the electrical charging unit did not have a preventive maintenance tag on it.</p> <p>3. At 1:45 PM on 9/16/2014, ICU Registered Nurse staff member #13 indicated the rechargeable razor was new and it was used for all the patients.</p> <p>4. At 2:45 PM on 9/16/2014, ICU was observed with a space heater in the nurse station. The space heater did not have a preventive</p>		<p>space heater policy H136 with employees during the upcoming mandatory Education Fair on 10/28/2014 and 10/29/2014 and provide a copy of that policy and a picture of the inspection sticker. Correction: Finding #s 1, 2, 3, 6--Education provided to Biomed and Material handlers on 09/16/2014 by Director of Healthcare Technology (HTM) using examples and demonstration. All Biomed staff asked to find existing units, do visual inspection, and attach labels. Findings 2,3,6--Inspected and labeled on 09/17/2014. HTM Director reviewed changes to policy H158 with Biomed and Material handlers. Policy to be updated by 11/03/2014. Actions documented in Biomed minutes from 09/30/2014 meeting. To prevent recurrence of this deficiency: Audits to be conducted by Biomed during annual walk-thru and semi-annual environmental tours by Safety Committee members. Documentation will be done through TMS system and work orders generated for any equipment found without an inspection label. Examples of incoming inspection requirements will be displayed at the mandatory Education Fair on 10/28/2014-10/29/2014. Responsible persons: Director of Plant Operations and Director of Healthcare Technology</p>		

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 09/17/2014
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	
	<p>maintenance tag on it.</p> <p>5. At 3:00 PM on 9/16/2014, ICU Registered Nurse staff member #33 indicated the space heaters were kept in the storage room and were brought out about three weeks ago. The staff member indicated 1 of 4 space heaters did not have a preventive maintenance sticker on it.</p> <p>6. At 3:15 PM on 9/16/2014, Clinical Engineer staff member #14 indicated the rechargeable razors are not documented as tested by the Clinical Engineering Department. The staff member confirmed the Clinical Engineering procedure requires all new equipment like the rechargeable razor to be checked before the patient care equipment can be put into service. The hospital does not maintain an inventory of low-risk equipment that is in service throughout the hospital.</p> <p>7. At 10:00 AM on 9/17/2014,</p>				

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 09/17/2014
--	---	--	---

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
S001172	<p>Physical Plant staff member #15 indicated he/she does not have documentation that the space heater has been tested before it was put into service.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on policy and procedure review, observation and interview, the hospital failed to maintain the environment of the Morgue in a sanitary and clean condition,</p>	S001172	Correction: Findings #s 1,2,3,4, and 5— Morgue has been deep cleaned, including removal of unnecessary items. Shelving will be removed and replaced with a	11/14/2014

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 09/17/2014
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	
	<p>failed to ensure that policies related to refrigerator cleaning and OB (obstetrics) unit C-Section room cleaning were implemented: and failed to ensure general facility cleanliness was maintained in other areas toured.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Community Hospital Anderson Instructions for cleaning Ancillary/Holding Areas Cleaning Schedule includes: Collect and remove waste; Wash walls & wall fixtures if needed; Clean and disinfect furniture, shelves, bedside tables, and window sills; Clean inside and outside sink, sink faucets and mirrors, soap and towel dispensers; clean and disinfect all furniture. At 1:40 AM on 9/15/2014, the eye bank removed a cornea from a patient in the Morgue. Community Hospital Anderson Environmental Daily Cleaning Sheet listed Morgue to be cleaned as needed. On 9/15/2014, the daily cleaning sheet identified the Morgue was cleaned. The log only noted the trash was emptied, wet mop floor, dust. The columns that identified shelves, wall, sinks, furniture to be cleaned was not marked as being 		<p>smaller unit. Non-essential items located in area around the sink have been removed. Area to be painted and any necessary facility repairs will be made at that time. To prevent recurrence of this deficiency: The morgue will be checked daily. The area will be added to the weekly cleaning schedule. EVS staff to be notified when area has been used. Policy developed to reflect cleaning schedule. Responsible persons: Director of Laboratory Services and Director of Environmental Services and Facilities Date of Correction: 11/04/2014 Correction: Findings #s 1, 6, 7, 8—Refrigerators, microwaves cited were cleaned immediately. Findings 12 and 15 ED--Sink was cleaned immediately and box of gloves were discarded. Finding #13 Blanket warmer was dusted . Finding #14 All hanging plants were removed from the area and nursing station was dusted. Findings #s 16, 17, 18, 19 All computers on wheels were dusted as were ledges in nursing stations. Finding #20 Silk plant removed from area. All silk plants removed from patient care areas and those in non-patient care areas were cleaned and returned. Findings # 22 thru 26 Lights cleaned of all bugs and dust. Ceiling vents cleaned. To prevent recurrence of this deficiency: Findings # 12, thru 26—The VP of Patient Care</p>		

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 09/17/2014	
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			
	<p>done.</p> <p>4. At 1:18 PM on 9/16/2014, the Morgue was observed with a pan of water in the hand washing/emergency eye station sink basin. The sink faucet was encrusted with white substance around the faucet agitator. Inside the sink basin was heavily caked on with a white substance. The steel shelving unit storing supplies was observed heavily caked on with dust, rust, and other soil residue. On the soiled shelves were boxes of exam gloves. Gloves from these boxes were loose, lying on the rust and soil residue that was on the shelves. The shelves also had boxes of processing embedding cassettes (used for biopsies) that were lying outside these boxes on the soiled shelves and a few were lying on the floor. On a lower shelf were over 10 manual staining lids for the lab dated 12/7/07. The floor was soiled with dirt and grime. On the top shelf was soiled blue and yellow aprons.</p> <p>5. At 2:45 PM on 9/15/2014, EVS staff member #35 indicated the Morgue is cleaned as needed or after it was used for an autopsy or a cornea extraction. The staff member indicated housekeeping staff noted the Morgue was cleaned after it was used earlier in the day. However, the staff member confirmed the</p>		<p>Services shared the following communication with all Directors: Managers or their designees are to complete weekly environmental audits to then be turned in to their Directors for review. The audits should include, at a minimum the following items: · Refrigerators · Microwaves · Personal spaces – desks, phones, computers, shelves, etc. · Computers · Computers on Wheels · Patient equipment · Ceiling tiles/vents · Staff/Public Restrooms Items should be assessed for cleanliness and proper working order. If an item needs to be addressed that is outside of your scope to clean/repair, please generate a work order to the appropriate department. Please note if you already have a process for ongoing audits you may continue that same process as long as all the items above are addressed and are then reviewed by the Director of that area. Responsible persons: Department Managers and Directors, including Director of Environmental Services and Facilities. Correction: #9 thru #11 Area immediately cleaned. Findings discussed with surgery staff in morning huddles on 09/17/2014 thru 09/19/2014. Policy reviewed "Environmental Cleaning in the Surgical Practice Setting". To prevent recurrence of this deficiency: All staff required to review the policy and sign-off to indicate understanding. Staff</p>				

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 09/17/2014
--	---	--	---

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
	<p>room was not cleaned like it should have been. The pan that was observed in the hand washing sink was for the staff that did the cornea extraction. The staff member indicated the pan should have been removed.6. Review of the Infection Control Policy "Monitoring and Routine Care of Refrigeration Systems", no policy number, last revised 8/11, indicated:</p> <p>a. under "Text: A. General:", it reads: "1. Units will be cleaned as needed to maintain clean surfaces. All employees using the refrigerator/freezer are responsible for wiping up any messes occurring between cleanings. 2. Units will be defrosted as needed to help maintain proper functioning and temperature control..."</p> <p>7. At 2:20 PM on 9/15/14, while on tour of the Peds nursing unit, in the company of the OB unit nurse manager, #66, (peds nurse manager was off) it was observed in the pantry area that:</p> <p>a. The refrigerator gasket of the obstetrics drink refrigerator was dirty (crumbs and debris) and there were discolored chocolate bits in the freezer portion of the refrigerator.</p> <p>b. The top of the peds refrigerator (outside) had a dried liquid spill on it and the "handles" (concave/scoop type) of the refrigerator were dirty with a dried liquid.</p> <p>c. The microwave was dirty with dried</p>		<p>instructed to call surgery supervisors if time does not allow for proper cleaning and inspection of the suite. Surgery supervisors will provide staffing resources for proper cleaning and inspection. Responsible persons: Surgery Clinical Manager and Director of Surgical Services Date of Correction: 10/31/2014</p>	

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 09/17/2014
--	---	--	---

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
	<p>splattered food on the turntable, sides and top of the machine's interior.</p> <p>8. Interview with staff member #66 at 2:25 PM indicated:</p> <p>a. There was agreement that the items listed in 2. above were dirty.</p> <p>b. There is no facility policy related to the cleaning of microwaves.</p> <p>c. Nursing staff are responsible for the cleaning of the refrigerators.</p> <p>9. Review of the policy and procedure "OB/OR (obstetrics/operating room) Cesarean Section (OB-32)", no policy number, last reviewed on 6/5/14, indicated:</p> <p>a. On page 2 under section "2.", it reads: "The Surgery department will...g. clean the room after use...".</p> <p>10. At 11:20 AM on 9/16/14, in the company of staff members #59, the surgery director, and #60, the surgery clinical manager, while on tour of the OB surgery suite (for C Sections), it was observed that:</p> <p>a. The suite had packs out (unopened) in preparation of the next C Section.</p> <p>b. The surgical table had linens on it, also in preparation of the next C Section.</p> <p>c. There were a minimum of 3 strings of suture on the floor from the last C Section (length of the sutures was > 6</p>			

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 09/17/2014
--	---	--	---

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
	<p>inches).</p> <p>d. There were betadine splashes on the floor from the last C Section performed earlier that morning.</p> <p>e. The handle covers were still on the overhead lights from the last C Section.</p> <p>11. At 11:25 AM on 9/16/14, interview with staff members #59 and #60 indicated:</p> <p>a. Surgery staff are in charge of the OB surgical suite.</p> <p>b. The room was considered to be "clean" and ready for the next patient.</p> <p>c. The handle covers on the overhead surgical lights were from the sterile packs of the last C Section patient and should have been removed during a terminal cleaning process.</p> <p>d. Surgery staff had failed to terminally clean the suite appropriately in regards to the handle covers on the overhead lights and in the lack of cleaning of the floor after the last C Section, and prior to placing linens on the surgical table and surgical packs on tables.</p> <p>12. At 11:20 AM on 9/15/14, while on tour of the ED (emergency department) Fast track area in the company of staff member #53, the nurse manager of the ED, it was observed that:</p> <p>a. The sink in the medication room had a pink sticky substance around the</p>			

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 09/17/2014
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	
	<p>handles and faucet.</p> <p>b. The box of non sterile gloves beside the sink was saturated clear through from the splash of hand washing.</p> <p>13. At 11:35 AM on 9/15/14, while on tour of the ED in the company of staff member #53, the nurse manager of the ED, it was observed that the top (outside) of the Getinge blanket warmer was extremely dusty.</p> <p>14. At 12:15 PM on 9/15/14, while on tour of the ED in the company of staff member #53, the nurse manager of the ED, it was observed that:</p> <p>a. The hanging baskets (>6) outside the nurses' station were covered in dust.</p> <p>b. The edge of the window surrounding the nurses' station was dusty.</p> <p>15. At 12:20 PM on 9/15/14, interview with staff member #53 and #54, the housekeeping manager, indicated:</p> <p>a. The hanging baskets are taken down and cleaned twice/year, but they currently appear dusty.</p> <p>b. The fast track area, as listed in 7. above, had a dirty sink and soggy glove box.</p> <p>c. The fast track area is open from 3 PM to 11 PM and should have been cleaned by this AM (by the time of surveying at 11:20 AM).</p>				

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 09/17/2014	
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			
	<p>d. Housekeeping is failing to keep the dust level down on the unit as evidenced by the dusty blanket warmer and window ledge outside the nurses' station.</p> <p>16. At 1:45 PM on 9/15/14, while on tour of the peds nursing unit in the company of staff member #66, the ob nursing manager, it was observed that the computer on wheels (COW) had a large amount of dust on the lower base area.</p> <p>17. Interview with staff member #66 at 1:45 PM on 9/15/14 indicated there was agreement that the COW was extremely dusty on the base area and that nursing staff are failing to keep these cleaned.</p> <p>18. At 2:35 PM on 9/15/14, while on tour of the OB unit in the company of staff member #66, the unit manager, it was observed that:</p> <p>a. One of the COWs had dust on the lower base shelf of the unit.</p> <p>b. The window ledge surrounding the nurses' station was dusty.</p> <p>19. Interview with staff member #66 at 2:40 PM on 9/15/14 indicated there was agreement that the areas listed in 13. above were dusty, as stated.</p> <p>20. At 2:45 PM on 9/15/14, while exiting the OB unit in the company of</p>						

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 09/17/2014
--	---	--	---

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
	<p>staff member #50, the vice president of patient care services, it was noted that the tall (5 feet) silk type potted plant in the entryway was extremely dusty.</p> <p>21. Staff member #50 agreed, at 2:45 PM on 9/15/14, that the plant listed in 15. above was very dusty.</p> <p>22. At 11:20 AM on 9/16/14, while on tour of the OR area of the facility in the company of staff member #59, the OR director, it was observed that an overhead light just outside the women's changing room (outer core of the surgery area) had 14 dead bugs in it.</p> <p>23. At 11:25 AM on 9/16/14, while leaving the OR to take the elevator to the OB C Section room, in the hallway outside of the OR, it was noted that >6 dead bugs were found in the overhead light.</p> <p>24. At 11:20 AM and 11:25 AM on 9/16/14, interview with staff member #59 indicated the overhead lights, as listed in 17., and 18. above had dead bugs present.</p> <p>25. At 11:35 AM on 9/16/14, while moving to the interventional radiology (IR) area, in the company of staff member #67, a quality resources staff member, it was noted that the overhead</p>			

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 09/17/2014
--	---	--	---

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
S001510	<p>ceiling vent outside the IR door was extremely dusty.</p> <p>26. At 11:40 AM on 9/16/14, interview with staff member #67 indicated that there was indeed an accumulation of dust on the ceiling vent.</p> <p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following:</p> <p>(A) Provision for the care of the disturbed patient.</p> <p>(B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care.</p> <p>(C) Provision for transfer of patients when care is needed which cannot be</p>			

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 09/17/2014	
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			
	<p>provided.</p> <p>Based on policy and procedure review, medical record review, and interview, the facility failed to ensure that nursing staff implemented the transfer policy for 1 of 1 patients transferred from a nursing unit to another acute care facility. (pt. #19)</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Patient Transfer", no policy number noted, last revised 5/11, indicated:</p> <p>a. Under "Policy Statement (S):", it reads: "1. The Nursing Department of [this facility] will make arrangements for the transfer of patients within the hospital and to other facilities for emergency, diagnostic or therapeutic purposes."</p> <p>b. On page 2, under "Action Steps:", it reads: "All Transfers:...2. A transfer summary appropriate to the unit shall be completed..."</p> <p>2. Review of patient medical records indicated pt. #19 was transferred from the ICU (intensive care unit) to another acute care hospital on 9/3/14, but lacked a transfer form in the medical record.</p> <p>3. At 1:00 PM on 9/17/14, interview with staff member #67, a quality resource staff member, indicated:</p> <p>a. Pt. #19 had a long had note by nursing staff indicating the family was aware of the transfer and what facility they were being transferred to, but there was no transfer form in the medical record.</p> <p>b. A phone call to the receiving hospital was made and no transfer form could be found in their medical record for patient #19, either.</p> <p>c. Nursing staff failed to follow facility policy with the lack of completion of a transfer form for this patient.</p>	S001510	<p>Correction: Clinical Manager provided education to all ICU staff. Communication provided through email, posting of policy—"Patient Transfer" #374 and fliers on communication board. Additionally, policy reviewed with management team and policy forwarded to all ICU staff by email with request of read receipt. To prevent recurrence of this deficiency: The ICU Clinical Manager will audit 100% of all transfers for accuracy and presence of transfer form. Audits will continue until process data reflects stability. Responsible person: ICU Clinical Manager</p>	10/16/2014			