

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2013
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NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 003312</p> <p>Survey Date: 4-1/3-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: cloughlin 04/15/13</p>	S000000		

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

TITLE

(X6) DATE

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

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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for 2 of 4 medical staff credential files reviewed and 2 of 2 allied health files reviewed.</p> <p>Findings:</p> <p>1. Review of a medical staff policy and procedure entitled CARDIOPULMONARY RESUSCITATION (CPR) REQUIREMENTS, approved 5-13-12, indicated it is a requirement these</p>	S000318	<p><b>Short Term Remedy:</b> Director for Medical Staff Services (MSS) and Coordinator – MSS will submit a revised draft policy to Chief Medical Officer (CMO), for review prior to submission to Community Heart and Vascular Hospital (CHVH) Medical Executive Committee (MEC). The goal of the revisions will be to:</p> <ul style="list-style-type: none"> <li>· Address any ambiguity regarding competency language.</li> <li>· Exclude Allied Health Providers (AHPs), since their requirements are included in our AHP Policies and Procedures Manual.</li> <li>· Address any needs for pediatrics ICU (PALS).</li> <li>· Include "Approved as written" next to approval dates on policy Once CMO has provided pre-approval, MSS will then take</li> </ul>	06/10/2013			

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	<p>physicians [Emergency Medicine physicians present in the Emergency Department] either be board certified in Emergency Medicine or have Advanced Cardiac Life Support (ACLS). The policy did not indicate what other criteria was used to determine CPR competency for other than Emergency Medicine physicians, anesthesiologists and in-house cardiologists.</p> <p>2. Review of 4 medical staff credential files indicated files MD#1(a cardiovascular surgeon) and MD#4 (an Emergency Medicine physician) did not have any documentation of CPR competency in accordance with hospital policy and current standards of practice.</p> <p>3. In interview, on 4-2-13 at 10:25 am, employee #A25 confirmed the above and no further documentation was provided prior to exit.</p> <p>4. Review of a medical staff policy and procedure entitled CARDIOPULMONARY RESUSCITATION (CPR) REQUIREMENTS, approved 5-13-12, indicated many of our other physicians (and AHPs) [Allied Health Practitioners] maintain competence in CPR, but this is not a requirement. The policy did not indicate what other criteria was used to</p>		<p>policy to CHVH MEC on June 10, 2013, and then for Board approval. Policy is attached. Per initial policy, Emergency Physicians are considered competent in CPR as evidenced by their board certification in Emergency Medicine. According to original policy, Many of our other physicians (and AHPs) maintain competence in CPR, but this is not a requirement. <b><u>Date Started:</u></b> April 10, 2013 <b><u>Date to be Completed:</u></b> June 10, 2013 <b><u>Long Term Remedy:</u></b> Once approval is received by CHVH MEC and the Board, MSS will immediately communicate new policy requirements to all affected providers via email and U.S. mail. MSS will take the following steps to ensure that affected providers meet policy requirements. 1. Set up query in Cactus system to enable email reminders that automatically and timely remind providers of forthcoming CPR expirations, as applicable. 2. Track completion of CRP, by provider, in Cactus. 3. Generate follow-up query to ensure compliance. 4. Escalate non-compliance, per Bylaws. <b><u>Date Started:</u></b> June 11, 2013 <b><u>Date to be Completed:</u></b> August 31, 2013 for current providers (ongoing) <b><u>Plan to prevent future recurrence:</u></b> Using the query, tracking, and follow-up mechanisms described above, MSS will be able to monitor compliance and address</p>				

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	<p>determine CPR competency for AHPs in accordance with hospital policy and current standards of practice.</p> <p>5. Review of 2 AHP files indicated AH#1 had no documentation of CPR and AH#2 had documentation of CPR that expired 9-2-2008.</p> <p>6. In interview, on 4-2-13 at 2:20 pm, employee #A21 confirmed the above regarding AHPs and no further documentation was provided prior to exit.</p>		<p>non-compliance issues. <u>Who is responsible for numbers 1 &amp; 2 above?</u> (Not by name, but by position) Director for Medical Staff Services <u>What date will deficiency be corrected?</u> ( Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)August 31, 2013 for current providers (ongoing)</p>		

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S000406	<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 3 services (Endoscopy, Nuclear Medicine, and Ultrasound) were included in its comprehensive quality assessment and improvement and Safety Plan (QA&amp;I).</p> <p>Findings included:</p> <p>1. Organizational Performance Improvement and Safety Plan 2013 states, "Community Health Network's Mission, Vision, Values and Leadership and Quality Philosophies by reflecting the</p>	S000406	<p><b>Short Term Remedy:</b> · Site Leader for Quality Resources met with the supervisors from each area where these types of procedures are performed (Endoscopy, Ultrasound, &amp; Nuclear Medicine). · Indicators were developed to monitor the services provided and were added to the Quality Indicator Database. · Data collected from January 1, 2013 and will be collected throughout 2013. <b>Date Started:</b> April 10, 2013<b>Date to be Completed:</b> April 10, 2013 <b>Long Term Remedy:</b> · Site Leader for Quality Resources will ensure that services offered to the patients at Community Heart &amp; Vascular Hospital are reflected in our quality monitoring program. <b>Date Started:</b> April 10, 2013 <b>Date to be Completed:</b> April 10, 2013 and ongoing <b>Plan to prevent future recurrence:</b> ·</p>	04/10/2013

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	<p>Network's framework for designing, measuring, assessing, and continuously improving the care and services we provide. Organizational Performance Improvement and Safety Plan is intended to cover the full scope of the organization's services in regard to performance quality and safety."</p> <p>2. Review of the facility's QA&amp;I program with staff member #L23 at 2:00 PM on 4/2/2013, indicated it did not include clinical services: Endoscopy, Nuclear Medicine, and Ultrasound.</p> <p>3. At 2:00 PM on 4/2/2013, staff member #L23 confirmed Endoscopy, Nuclear Medicine, and Ultrasound documentation of monitoring and evaluation of the services could not be provided.</p>		<p>Site Leader for Quality Resources will ensure that services offered to the patients at Community Heart &amp; Vascular Hospital are reflected in our quality monitoring program. <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position) Site Leader for Quality Resources <b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month-Day- Year. Maximum correction time allowed is 30 days from the date of survey.)April 10, 2013 and ongoing _</p>	

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S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on observation and interview, the facility failed to maintain sanitation of 2 refrigerator/freezers and 1 microwave, failed to maintain sanitation of 1 HMS Plus Medtronic device, and failed to maintain the sanitation of 3 accu-chek and 2 I Stat devices in 4 of 8 areas toured.</p> <p>Findings included:</p> <p>1. During tour of the facility on 4-1-13 and 4-2-13 the following was observed: a. On 4-1-13 at approximately 10:40 AM in the presence of S20, the inside of the GE refrigerator in the Emergency Medical Services break room area of the Emergency Department (ED) was observed to be soiled with debris and stains of dried fluid.</p>	S000592	<p>#1 a,b,c <b>Short Term Remedy:</b> · All refrigerators and microwaves were cleaned immediately. · Any freezer compartment found to be in need of defrosting was defrosted immediately. <b>Date Started:</b> 4/2/13 <b>Date to be Completed:</b> 4/2/13 <b>Long Term Remedy:</b> · Staff in NFS were reeducated on the cleaning expectations per policy and Cleaning Responsibility Form in one on one meetings and in a staff meeting scheduled for May 15, 2013. · Staff on the units were reeducated on the cleaning expectations per policy and Cleaning Responsibility Form in one on one meetings and in emails from management to staff. · Cleaning responsibilities will be covered in next Team Days for all units (from May thru June). <b>Date</b></p>	05/15/2013			

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	<p>b. On 4-1-13 at approximately 10:40 AM in the presence of S20, the inside of the microwave in the Emergency Medical Services break room in the ED was observed to be soiled with debris and stains of dried fluid.</p> <p>c. On 4-1-13 at approximately 12:20 PM in the presence of S20, the inside and outside of the GE refrigerator/freezer in the Daybed unit hall C was observed to be soiled with debris and stains of dried fluid. The freezer compartment had a thick coating of ice. There was no log in the area indicating a schedule for defrosting or tracking when the freezer had been defrosted.</p> <p>d. On 4-1-13 at approximately 3:00 PM in the presence of S3, the HMS Plus Medtronic heparin dose response point of care testing device in Operating Room #4 was noted to have a splattered dried red substance around the testing area of the device.</p> <p>e. On 4-1-13 at approximately 4:00 PM in the presence of S7, 3 accu-chek and 2 I stat point of care devices in the Recovery Room were observed to contain soiled areas, dust, debris, and stains of dried fluid particularly in the well of the base unit where the hand-held units are stored between uses.</p> <p>2. During interview with the Infection Control Officer, S15, on 4-2-13 at</p>		<p><b>Started:</b> 5/1/13 <b>Date to be Completed:</b> 5/15/13 and ongoing <b>Plan to prevent future recurrence:</b> · Patient Care Coordinators will be responsible for checking to ensure that refrigerators and microwaves are cleaned according to expectations at the end of each shift. · NFS director will perform periodic inspections of patient nourishment refrigerators to ensure that cleaning is performed according to expectations and policy. <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) NFS director Unit Management <b>What date will deficiency be corrected?</b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.) May 15, 2013 and ongoing # 1 d <b>Short Term Remedy:</b> · Dried splatter was cleaned immediately. · OR manager spoke with chief perfusionists on 4/1/13 regarding the need for equipment to be cleaned completely after each use. · Chief perfusionists met individually with all perfusionists reeducating them on the need for equipment to be cleaned completely after each use. <b>Date Started:</b> 4/1/13 <b>Date to be Completed:</b> 4/1/13 <b>Long Term Remedy:</b> · Signage was posted in the perfusionists office as a reminder of the need to ensure</p>		

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	<p>approximately 12:15 PM, S15 indicated:</p> <p>a. all refrigerators, freezers, microwaves, and point of care testing devices should be sanitary and assigned regularly scheduled cleaning and disinfection in accordance with manufacturer's guidelines to prevent the transmission of disease causing bacteria and viruses.</p> <p>b. the facility policy for point of care devices does not include a provision for the sanitation of the base units for point of care devices to include cleaning and disinfection of the base units for accu-chek and I Stat devices. Placing the hand held devices which have been disinfected into a base unit which is not sanitary may result in contamination of a previously disinfected device.</p> <p>3. During interview with S3 on 4-1-13 at approximately 3:00 PM, S3 indicated:</p> <p>a. the HMS Plus device in Operating Room #4 was in a room which had been used for patient care on 3-29-13 and had been terminally cleaned at the end of the day. OR #4 was ready for patient use at the time of the tour.</p> <p>b. the HMS Plus device is the responsibility of the perfusionist to operate, maintain, and disinfect.</p> <p>c. the dried fluid observed on the testing area of the HMS Plus appeared to be dried blood.</p>		<p>that all equipment be cleaned completely after each use. <b><u>Date Started:</u></b> 4/29/13 <b><u>Date to be Completed:</u></b> 4/29/13 and ongoing <b><u>Plan to prevent future recurrence:</u></b> OR manager will perform periodic inspections to ensure that all equipment is satisfactorily cleaned. <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position) OR manager <b><u>What date will deficiency be corrected?</u></b> (Must provide specific date-Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey. 4/29/13 and ongoing # 1 e <b><u>Short Term Remedy:</u></b> · Manufacturer cleaning instructions were located and placed by all Point of Care Testing devices for staff reference. · All devices were cleaned according to manufacturer's specifications. · Signage was placed above all Point of Care Testing locations reminding staff of need to clean device after each use and base when scheduled and when soiled. · Schedule developed for cleaning of bases. <b><u>Date Started:</u></b> 4/29/13 <b><u>Date to be Completed:</u></b> 4/29/13 and On-going <b><u>Long Term Remedy:</u></b> · Unit staff will be reeducated on Point of Care device cleaning expectations during their next team days (May thru June). · Unit Patient Care Coordinators responsible for ensuring that all POC devices</p>		

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	<p>4. During interview with S20 on 4-1-13 at approximately 11:00 AM, S20 indicated:</p> <p>a. the microwave and refrigerator/freezer in the EMS break room are not on a routine cleaning schedule and were soiled</p> <p>b. the freezer compartment of the GE refrigerator/freezer in the Daybed unit was soiled;</p> <p>the freezer had 1-2 inches of ice in it; the freezer was in need of defrosting; and no documentation of regularly scheduled defrosting of the freezer was maintained. It could not be determined when the freezer had last been defrosted.</p>		<p>and bases are clean prior to the end of their shift. <b><u>Date Started:</u></b> 5/15/13 <b><u>Date to be Completed:</u></b> 5/15/13 and ongoing <b><u>Plan to prevent future recurrence:</u></b> Unit management will perform periodic inspections to ensure that Point of Care Devices are clean and free of debris. <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position) Unit Management <b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)5/15/13 and ongoing</p>	

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S000606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on document review and staff interview, Indiana Heart Hospital failed to report, to the person-in-charge, information about their health and activities as they relate to diseases that are transmissible through food upon a conditional offer of employment for 3 of 4 dietary staff members (#L17, #L25, and #L27).</p> <p>Findings: 1. Indiana Code 410 IAC 7-24-120 Sec 120, Retail Food Establishment Infection Control Requirements states "The owner or operator of a</p>	S000606	<p><b>Short Term Remedy:</b> · All food and nutrition services employees <i>reviewed</i> and signed Community Health Network's Infection Prevention Policy for Food Services. Signed copied of the policy were placed in all employee's HR and departmental files. <b>Date Started:</b> · Employees began reviewing and signing infection prevention policy for food services on April 2, 2013. <b>Date to be Completed:</b> · April 15, 2013 all infection prevention policies for food services signed and placed in HR and departmental files. <b>Long Term Remedy:</b> · All food and nutrition services employees will be in serviced about Infection Prevention for Food Services. ·</p>	05/31/2013			

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	<p>retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), of the food employee or applicant: (1) is diagnosed with an illness due to:(A) Salmonella spp.; (B) Shigella spp.; (C) Shiga toxin-producing Escherichia Coli; (D) Hepatitis A virus; or (E) Norovirus "</p> <p>2. Staff member #L26 signed an agreement between Community Health Network and the staff member. The staff member transferred from Community Hospital North to Indiana Heart</p>		<p>All food and nutrition services staff are in the process of being certified/re-certified through ServSafe®. All employees will be certified/re certified by May 31, 2013 · Infection Prevention for Food Services is on the agenda for the May 15, 2013 food and nutrition services departmental meeting, as a topic of discussion. · All food and nutrition services staff are in the process of being certified/re-certified through ServSafe®. All employees will be certified/re certified by May 31, 2013. <b><u>Date Started:</u></b> · ServSafe® certification/recertification started on April 24, 2013. <b><u>Date to be Completed:</u></b> · All food and nutrition services employees will receive in service training about infection prevention for food services at May 15, 2013 department meeting. Employees absent from the department meeting will receive the in service training by May 31, 2013. · All food and nutrition services employees will receive initial ServSafe® certification/recertification by May 31, 2013. Plan to prevent future recurrence: · All food and nutrition services employees will receive annual training about infection prevention for food services. · All new hires will be provided with the "infection prevention policy for food services" and asked to review/sign at time of new hire</p>	

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NAME OF PROVIDER OR SUPPLIER  INDIANA HEART HOSPITAL THE				STREET ADDRESS, CITY, STATE, ZIP CODE 8075 N SHADELAND AVE INDIANAPOLIS, IN 46250			
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	<p>Hospital (d/b/a Community Heart and Vascular Hospital). The agreement was referencing the requirements of 410 IAC 7-24-120. The agreement stated at the bottom of the page, "I have read (or had read to me) and understand the requirements concerning my responsibilities under the Indiana Food Code and this agreement." Staff member #L26 signed this agreement on 3/1/2013 at Community Hospital North. However, foodservice staff members #L17, #L25, and #L27 did not have evidence of the same agreement document in their personnel files.</p> <p>3. At 12:00 PM on 4/1/2013, staff member #L17 (Contractor - Food Director) indicated when he/she started at Indiana Heart Hospital, the staff member was not advised on how to report information to the hospital about his/her health and activities as they relate to diseases that are transmissible through food.</p> <p>4. At 2:15 PM on 4/2/2013, staff member #L8 confirmed staff</p>		<p>departmental orientation. Who is responsible for numbers 1 &amp; 2 above? (Not by name, but by position) Food and Nutrition Services Director</p>				

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	members #L17, #L25, and #L27 did not have evidence of the Dietary Infection Control agreement document in their personnel files. The staff member indicated the agreement was a Community Health Network policy and did not know why the agreement was not being followed at Indiana Heart Hospital.				

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S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation and staff interview, the facility failed to ensure all staff working in the Laboratory/Blood Bank or visiting the department are wearing lab coats to protect from possible infectious exposure.</p> <p>Findings included:</p> <p>1. MACL BBP Exposure Control/Infection Control Plan (last approved 3/15/2012) indicates Universal Precautions will be observed to prevent contact with</p>	S000608	<p>Deficiency correction: (If already corrected, include the steps taken and the date of correction). <b>Short Term Remedy:</b> · Any person in the lab/ blood bank area will be required to wear a lab coat while in this department. All staff was notified via email and signs were posted in the department. <b>Date Started:</b> · 5/13/13 <b>Date to be Completed:</b> · 5/13/13 <b>Long Term Remedy:</b> · MACL supervisor will ensure that all staff are aware that anyone in the department must wear lab coat. This will be included to new MACL staff orientation. Plan to prevent future recurrence: · Lab area will be monitored when supervisory staff is on the premises. Who is responsible for numbers 1 &amp; 2 above? (Not by</p>	05/13/2013			

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	<p>blood and other potentially infectious materials. Associates at risk of occupational exposure will be provided appropriate personal protective equipment (PPE) by the Laboratory. The use of PPE helps prevent occupational exposure to infectious materials. Lab Coats are to be worn by all associates working in an area where the possibility of blood exposure or other infectious materials exists. All visitors must wear lab coats in the Laboratory Department.</p> <p>2. At 1:15 PM on 4/2/2013, the Laboratory/Blood Bank Department was inspected. The single room was approximately 25-feet by 25-feet with assorted refrigeration units and assorted testing equipment. The room handles assorted laboratory tests. The Laboratory was observed with 3 staff members. The staff members work for the contracted company (MACL). Two of the staff members were observed wearing blue lab coats while the</p>		<p>name, but by position) MACL Lab Supervisor What date will deficiency be corrected? (Must provide specific date- Month-Day- Year. Maximum correction time allowed is 30 days from the date of survey.) May 13, 2013</p>		

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	<p>other staff member was sitting at the counter adjacent to lab testing equipment wearing no lab coat.</p> <p>3. At 1:20 PM on 4/2/2013, laboratory staff member #28 indicated that visitors to the Laboratory did not have to wear lab coats.</p> <p>4. At 1:40 PM on 4/2/2013, staff member #L14 indicated he/she had concerns with 1 of the 3 laboratory associates not wearing a lab coat. The staff member indicated the one laboratory associate was just working on a computer but was within arm reach of a blood lab testing equipment. The staff member indicated a MACO procedure requires visitors to wear laboratory coats while in the department.</p>				

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S000610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on document review, observation and interview, the hospital failed to follow its policy of storage of food in a medication storage refrigerator and failed to monitor temperature of 2 refrigerator/freezers in 2 of 8 units toured.</p> <p>Findings:</p> <p>1. Review of hospital policy</p>	S000610	<p><b>Short Term Remedy:</b></p> <ul style="list-style-type: none"> <li>·The food item was immediately removed from the freezer.</li> <li>·The policy regarding proper medication storage (which addresses that food must not be kept in the same refrigerator/freezer as medications) has been reviewed with the department.</li> <li>·All refrigerators and freezers have been labeled as</li> </ul>	04/11/2013	

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	<p>PPP#Dist014, entitled STORAGE/STORAGE TEMPERATURES/REFRIGERATION, indicated food and other non-drug items shall not be stored in the same refrigerator as drugs.</p> <p>2. On 4-1-13 at 2:35 pm, in the presence of employees #A11, #A23 and #A24, it was observed in the Pharmacy that there was a 2.75 pound container of heath cookie dough stored in a refrigerator.</p> <p>3. In interview, on the above date and time, employee #A11 indicated the refrigerator was used for the storage of medications and there should not have been food stored in it.</p>		<p>appropriate:</p> <ul style="list-style-type: none"> <li>·Food Refrigerators = **FOOD ONLY, NO MEDICATIONS**</li> <li>·Medication Refrigerators/Freezers = **MEDICATIONS ONLY** **NO FOOD/DRINKS**</li> </ul> <p>As consistent with the networks Corrective Action policy, the individual responsible for placing the food in the medication freezer has received "written counseling" in which the policy PPP # DIST014 was reviewed and expectations of behavior/compliance with policies were articulated and documented.</p> <p><b><u>Date Started:</u></b> April 1, 2013<b><u>Date to be Completed:</u></b> April 10, 2013<b><u>Long Term Remedy:</u></b> The Community Heart and Vascular Hospital Director of Pharmacy will do periodic inspections to ensure no items are stored in the improper location. <b><u>Date Started:</u></b> April 10, 2013 <b><u>Date to be Completed:</u></b> April 10, 2013 and ongoing <b><u>Plan to prevent future recurrence:</u></b> The Community Heart and Vascular Hospital Director of Pharmacy will do periodic inspections to ensure no items are stored in the improper location. <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position) Director of Pharmacy <b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month-Day- Year. Maximum correction time allowed is 30 days from the</p>		

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			<p>date of survey.)April 11, 2013 and ongoing <b>Short Term Remedy:</b></p> <ul style="list-style-type: none"> <li>· Temp Track has been added where able to full size refrigerators and freezers and will be monitored according to the Temp Track policy.</li> <li>· All dorm sized refrigerators in all areas are monitored via Temp Track according to the Temp Track policy.</li> <li>· All freezer compartments in dorm sized refrigerators have had thermometers added for temperature monitoring.</li> <li>· Temperature monitoring of Patient Nourishment refrigerators/ freezers is to be done twice daily by NFS staff. The paper monitoring log has been revised to reflect twice daily monitoring as per policy. <b>Date Started:</b> April 1, 2013<b>Date to be Completed:</b> April 10, 2013<b>Long Term Remedy:</b></li> <li>· NFS staff will be reeducated on NFS policy regarding the twice daily temperature monitoring during their May 15, 2013 staff meeting. <b>Date Started:</b> May 15, 2013 <b>Date to be Completed:</b> May 15, 2013 and ongoing <b>Plan to prevent future recurrence:</b> NFS director will do periodic inspections to ensure temperatures are being monitored as per policy. <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) Director of Nutrition and Food Services <b>What date will</b></li> </ul>		

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	<p>4. During tour of the facility on 4-1-13, between 10:50 AM and 12:20 PM, in the presence of S20, the following was observed:</p> <p>a. the refrigerator/freezer unit in the Emergency Department (ED) Emergency Medical Services (EMS) break room lacked a Temp Trak probe or thermometer in the refrigerator and freezer sections</p> <p>b. in the Daybed area, in the nurse station in hall C (rooms 141-148), the freezer portion of the GE refrigerator/freezer lacked a Temp Trak monitoring probe for the freezer and lacked a thermometer in the freezer compartment. There were 3 units of individual serving size ice cream stored in the freezer.</p> <p>5. Facility policy "Nourishment Rooms Refrigerator/Freezer Temperatures, Routine Monitoring", last reviewed/revised 1-5-12, provided on page 1, Patient Nourishment Refrigerator/Freezers:..B. "The Nutrition Food Services Department will monitor and record temperatures for refrigerators and freezers in each nourishment room</p>		<p><b>deficiency be corrected?</b> (Must provide specific date- Month-Day- Year. Maximum correction time allowed is 30 days from the date of survey.)May 15, 2013 and ongoing</p>	

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	<p>This will be done twice per day."</p> <p>6. Facility policy "Temperature Monitoring using Temp Trak" last reviewed/revised 11-2-12, provided page 1, 1, "Refrigerators/freezers in all areas utilized for the storage of supplies such as medications, lab specimens, and food should have a Temp Trak temperature sensore inside the unit".. and 3, "Standard Temperature Ranges....Nutrition Freezers -10 to 10 degrees Farenheit".</p> <p>7. Facility policy "Temperature Monitoring via Paper Logs" last reviewed/revised 12-6-12, provided page 1, 3, "Standard Temperature Ranges....Nutrition Freezers -10 to 10 degrees F, 32 to 40 degrees F.".</p> <p>8. During interview with S20 on 4-1-13 at approximately 12:20 PM, S20 indicated:</p> <p>a. the ED EMS refrigerator/freezer unit is used for storage of food and beverages for patient use and was stocked with food and beverages</p> <p>b. the refrigerator/freezer in the Daybed area is used to store nutrition items for patient use and contained 3 containers of ice cream</p> <p>c. the freezer lacked either a Temp Trak temperature probe for central monitoring or a thermometer and log for twice daily</p>						

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	<p>monitoring of the freezer compartment</p> <p>d. it could not be reliably determined that these units had been maintained at -10 degrees to 10 degrees Farenheit for freezer compartment and 32 to 40 degrees for refrigerated food as per facility policy</p> <p>e. the freezer and refrigerator units above had not been monitored for temperature as required by facility policy for an undetermined length of time and this presented a risk to patients if spoiled food was served</p>			

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S000744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on document review and interview, the facility failed to complete information on the "Care of the Patient After Death" form per facility policy for 2 of 3 death records reviewed.</p> <p>1. Facility policy "Medical Record Chart Requirements Inpatient and Medical Observation", last reviewed/ revised 12-2011, provided on page 1, Contents of the Medical Record, "All entries in the medical record must be legible, complete, dated, timed and authenticated in written or electronic form".</p> <p>2. Review of medical records of patients who had died while hospitalized, on 4-2-13 at approximately 4:00 PM, indicated:</p> <p>a. N6 was admitted on 6-14-12 and died on 7-12-12; the "Care of the Patient After Death" form lacked a response to item 5, Autopsy Permit Obtained and lacked the signature and title of the person completing the form.</p> <p>b. N8 was admitted on 9-3-12 and died on 9-11-12, the "Care of the Patient After</p>	S000744	<p><b>Short Term Remedy:</b> Community Heart and Vascular Hospital went live with EPIC electronic medical records in November 2012. The form "Care of the Patient After Death" was replaced with electronic documentation in the post-mortem flowsheet. Director of HIM is verifying required documentation with the CareConnect IT team for the post-mortem documentation. <b>Date Started:</b> 5/6/13 <b>Date to be Completed:</b> 5/13/13 <b>Long Term Remedy:</b> HIM will monitor electronic documentation in the post-mortem flowsheet for completeness. The results of these reviews will be provided to nursing leaders monthly. <b>Date Started:</b> 5/20/2013 <b>Date to be Completed:</b> 11/20/2013 <b>Plan to prevent future recurrence:</b> HIM will monitor all medical records of patients that have expired for 6 month for completeness of the post-mortem documentation by doing monthly medical record review and providing results to nursing leaders. <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) Director, Health</p>	05/13/2013	

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	<p>Death" form lacked a response to item 5, Autopsy Permit Obtained and lacked the signature and title of the person completing the form.</p> <p>3. During interview with S25 on 4-3-13 at approximately 11:00 AM, S25 confirmed the findings in the medical records above and indicated that the above forms for N6 and N8 were not completed as per facility policy. S25 stated each form should have included a response to item 5 regarding whether autopsy permit was obtained and the name and title of the person completing the form.</p>		<p>Information Management <u>What date will deficiency be corrected?</u> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)5/20/2013 and ongoing</p>		

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S000810	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(3)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(3) Make recommendations to the governing board on the appointment or reappointment of the applicant for a period not to exceed two (2) years. Based on document review and interview, the facility failed to follow its perfusionist contract by not approving of all qualified individuals provided by the perfusion company to be approved by the hospital and surgical staff for 2 of 2 perfusionist files reviewed.</p> <p>Findings:</p> <p>1. Review of a contract between The Indiana Heart Hospital (HOSPITAL) and Coastal Extracoporeal Technology [the COMPANY, provider of perfusionists], dated January 1, 2012, indicated all qualified individuals designated by the COMPANY who provide services at the HOSPITAL shall be subject to final approval of the HOSPITAL and Surgical</p>	S000810	<p><b>Short Term Remedy:</b> · Director for Medical Staff Services (MSS) will contact VP Quality and Risk Management, to request modification of Section 1.3 of the existing Perfusion Services/Supply Agreements, as follows (see text that has been stricken to reflect proposed correction): <i>1.3 Credentials The COMPANY agrees that qualified individuals who are to perform the services under this Agreement shall have received the designation of a "Certified Perfusionist" or "Autotransfusionist". The COMPANY shall provide the HOSPITAL with the proper qualifications and present the necessary material to the Credentials Committee for review and approval in accordance with</i></p>	06/10/2013			

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	<p>Staff.</p> <p>2. Review of 2 perfusionist files, AH#1 and AH#2, indicated for neither, there was no approval by the hospital and its surgical staff.</p> <p>3. In interview, on 4-2-13 at 2:20 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p>		<p><i>the HOSPITAL allied health professional bylaws, policies or procedures. All qualified individuals designated by the COMPANY to provide services at the HOSPITAL shall be subject to final approval of the HOSPITAL and Surgical Staff, which approval shall not be unreasonably denied or withheld.</i></p> <p>· Director for Medical Staff Services (MSS) and Coordinator – MSS will get approval from AHP leaders and MECs to quickly publish the already-approved revisions to the Allied Health Professionals Policies and Procedures Manual. Subsequent revisions can be reviewed and published at a later date when available. <b><u>Date Started:</u></b> April 10, 2013 <b><u>Date to be Completed:</u></b> June 10, 2013 <b><u>Long Term Remedy:</u></b> Coordinator – MSS will continue to work with AHP leaders and MECs regarding additional proposed revisions not yet approved, and timely publish with appropriate approvals <b><u>Date Started:</u></b> June 11, 2013 <b><u>Date to be Completed:</u></b> August 13, 2013 <b><u>Plan to prevent future recurrence:</u></b> Coordinator – MSS will schedule bi-annual meeting to review any proposed changes with AHP leaders, and then take to MECs for timely approval prior to publishing. <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position) Director for Medical</p>		

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			Staff Services <u>What date will deficiency be corrected?</u> (Must provide specific date- Month-Day- Year. Maximum correction time allowed is 30 days from the date of survey.)August 13, 2013 _		

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S001028	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent.</p> <p>Based on observation, document review, and interview, the facility failed to assure the security and access by authorized personnel only for 1 of 2 Electrophysiology (EP) rooms in 1 of 8 units toured.</p> <p>Findings included:</p> <p>1. On 4-1-13 at 2:30 PM, during tour of EP room 1, and in the presence of S18 and S20, the general anesthesia cart, drawer 2, unlocked, was observed to contain the following medications: 1 unopened Propofol 1% 20mL 1 unopened Glycopyrolate 1mL 1 open Rocuronium 5mL 1 open Neostigmine 10mL 1 open Droperidol 2mL</p>	S001028	<p><b>Short Term Remedy:</b> · Medications were immediately disposed of per policy. · Chief of Anesthesia met with all anesthesia physicians one on one to reeducate them on the Network "Pharmacy Security" policy. <b>Date Started:</b> 4/1/13 <b>Date to be Completed:</b> 4/10/13 <b>Long Term Remedy:</b> · At the end of each case in the cath lab/ EP area, the anesthesiologist will ensure that all medications are disposed of according to policy and are not accessible to unauthorized individuals. · Cath Lab manager &amp; Chief of Anesthesia (or their designee) will perform periodic inspections to ensure that that drugs are kept in locked storage when necessary and that unlocked drugs are inaccessible to unauthorized individuals. <b>Date Started:</b> 4/10/13 <b>Date to be</b></p>	04/10/2013			

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	<p>2. Facility policy, "Pharmacy Security", last reviewed/ revised 5-2012, provided on page 1 "Security precautions shall ensure that drugs are kept in locked storage when necessary and that unlocked drugs are inaccessible to unauthorized individuals".</p> <p>3. During interview with S18 on 4-1-13 at 2:30 PM, S18 indicated:</p> <p>a. the EP and Cardiac Catheterization rooms are in a restricted access area</p> <p>b. the housekeeping staff performs terminal cleaning of the room at the end of the day</p> <p>c. EP room 1 was last used on 3-29-13 for a general anesthesia case</p> <p>d. Housekeeping personnel are not authorized per facility policy to have access to drugs and clean this restricted area without direct supervision of an authorized staff member</p> <p>e. the above listed medications should not have been in an unlocked drawer in the general anesthesia cart and were not stored securely per facility policy.</p>		<p><b>Completed:</b> 4/10/13 and ongoing <b>Plan to prevent future recurrence:</b> Cath Lab manager &amp; Chief of Anesthesia (or their designee) will perform periodic inspections to ensure that that drugs are kept in locked storage when necessary and that unlocked drugs are inaccessible to unauthorized individuals. <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) Chief of Anesthesia <b>What date will deficiency be corrected?</b> (Must provide specific date- Month-Day- Year. Maximum correction time allowed is 30 days from the date of survey.) April 11, 2013 and ongoing</p>		

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 1 instance.</p> <p>Findings:</p> <p>1. On 4-1-13 at 12:40 pm in the presence of employees #A23 and #A25, it was observed in the Cardiac Testing storage area, there was an alcohol-based hand sanitizer (ABHS) on the wall directly above an electrical outlet.</p> <p>2. Due to the ABHS being directly above an electrical ignition source, this posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source.</p>	S001118	<p><b>Remedy:</b></p> <ul style="list-style-type: none"> <li>ABHS was immediately removed from its location above an electrical outlet and relocated to a safe area.</li> </ul> <p><b>Date Started:</b> 4/3/13 <b>Date to be Completed:</b> 4/3/13</p> <p>-</p> <p><b>Plan to prevent future recurrence:</b> Environmental rounds will be performed on a routine basis to ensure that areas of the hospital are kept free of patient safety issues.</p> <p><b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) Facilities director <b>What date will deficiency be corrected?</b> (Must provide specific date- Month-Day- Year. Maximum correction time allowed is 30 days from the date of survey.)April 3, 2013 and ongoing</p> <p>-</p>	04/03/2013	

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S001150	<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 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, the hospital failed to install a backflow prevention device as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.</p> <p>Findings:</p> <p>1. On 4-1-13 at 3:10 pm in the presence of employee #A23 and #A24, it was observed in the dialysis storage room there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S001150	<p><b>Remedy:</b> · A back flow device was installed in the dialysis storage room. · Signage was placed in dialysis storage room as a visual reminder of the need to have a back flow device in place.</p> <p><b>Date Started:</b> 4/3/13 <b>Date to be Completed:</b> 4/3/13 <b>Plan to prevent future recurrence:</b> Dialysis storage room will be added to environmental rounds and will be checked on a routine basis to ensure that backflow device is in place. <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position) Dialysis liaison <b>What date will deficiency be corrected?</b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.) April 3, 2013 and ongoing</p>	04/03/2013			