

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150169	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	<p>This visit was for one State hospital complaint investigation.</p> <p>Complaint Number: IN00099880 Substantiated: Deficiency cited related to the allegations.</p> <p>Date: 5-15-2012 and 5-16-2012</p> <p>Facility Number: 011437</p> <p>Surveyor: Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/19/12</p>	S0000		

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

TITLE

(X6) DATE

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

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S0936	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(6)</p> <p>(b) The nursing service shall have the following:</p> <p>(6) All nursing personnel shall demonstrate and document competency in fulfilling assigned responsibilities.</p> <p>Based on document review and interview, the facility failed to provide training in the safe use of a Hoyer lift for 3 of 3 employees that used the Hoyer lift.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Patient N1 was moved from a wheelchair to a hospital bed in the emergency department on 6-24-2011 at 21:15, using a Hoyer lift, by an ER nurse and 2 PCU nurses. 2. During interview with S8 on 5-15-2012 at 1:45 PM, S8 indicated: <ol style="list-style-type: none"> a. that only members of the lift team have training and competencies in the use of the Hoyer lift. b. the lift team was not available at the time of N1's ER visit on 6-24-2011. c. the ER nurse and PCU nurses that facilitated the transfer of N1 using the Hoyer lift did not have training and competency established in the use of the Hoyer lift. 	S0936	<p>Corrective Action based on ISDOH Citation: A content expert from the Lift Team will provide inservice education to nursing staff on use of the Hoyer Lift device (including ED and PCU nursing staff). The demonstration and inservice education is scheduled and will be completed prior to July 20th, 2012. Thereafter, education will be provided to new employees and periodically for current employees to maintain competency. Competency will be determined by post-test and/or return demonstration after education is completed for both new employees and ongoing for current employees. A policy was not located for use of the Hoyer lift, and is currently being developed. This will be in place by July 20th, 2012. Responsible Person(s): The Emergency Department Management Team and the Director with responsibility over the Lift Team.</p>	07/20/2012	

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	<p>3. During interview with S3 on 5-15-2012 at 1:50 PM, S3 confirmed the above findings.</p> <p>4. Policy and procedure for use of Hoyer lift was requested but not provided prior to exit.</p>			