

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150129	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY WESTVIEW HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3630 GUION RD INDIANAPOLIS, IN 46222
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S 000 Bldg. 00	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005110</p> <p>Survey Date: 2-2/4-15</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 02/25/15</p>	S 000		
S 270 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the</p>			

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

TITLE

(X6) DATE

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

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	<p>hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review, for the first quarter of calendar year 2014, reports of management operations of quality monitoring activities.</p> <p>Findings:</p> <p>1. Review of governing board minutes for calendar year 2014 indicated there was no review of quality activities.</p> <p>2.. In interview, on 2-4-15 at 10:40 am, employee #A5, Quality Resources network staff, indicated there was no documentation of the governing board having reviewed quality activities in the first quarter of calendar year 2015. No other documentation was provided prior to exit.</p>	S 270	<p>Issue Identified: Based on document review and interview, the governing board failed to review, for the first quarter of calendar year 2014, reports of management operations of quality monitoring activities.</p> <p>• Short Term Remedy: A quality report was provided to Community Westview Hospital Medical Executive Committee on 2/11/15 and documented in the minutes.</p> <p>• Date Started: 2/11/2015 • Date to be Completed: 2/11/15</p> <p>• Long Term Remedy: A quality report will be provided to Community Westview Hospital Medical Executive Committee at least 4 times per year and will be documented in the minutes. The Community Westview Hospital Medical Executive Committee minutes are reviewed by the governing board.</p> <p>• Date Started: 2/11/15• Date to be Completed: ongoing</p> <p>• Plan to prevent future recurrence: The Quality Resources</p>	02/11/2015	

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S 330 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review and interview, the facility failed to ensure that employees had current tuberculosis</p>			S 330	<p>department will ensure a quality report is reported at least 4 times per year to the Medical Executive Committee.</p> <ul style="list-style-type: none"> • Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Quality Supervisor and/ or Regulatory Coordinator • 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.) February 11, 2015 and ongoing <p>Issue Identified: Poor compliance and tracking of annual Tuberculin testing</p>		02/18/2015

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	<p>immunity on 18 (P2, P4, P5, P6, P7, P8, P9, P10, C#1, C#2, C#3, C#4, C#8, C#9, N3, N5, N7 and N8) of 30 personnel files reviewed.</p> <p>Finding:</p> <p>1. Review of facility personnel records indicated that P2, P4, P5, P6, P7, P8, P9, P10, C#1, C#2, C#3, C#4, C#8, C#9, N3, N5, N7 and N8 did not have any documentation of current (within 1 year) tuberculosis immunity.</p> <p>2. In interview, on 2-3-2015 at 2:15 pm, employee #A7, Human Resource Manager, confirmed the lack of documentation and no further documentation was provided prior to exit.</p>		<ul style="list-style-type: none"> • Short Term Remedy: All current employees who meet the definition of healthcare worker completed a Tuberculosis Questionnaire. The screening will be reviewed by a member of the Work-Site Care Clinic for answer of "yes" to the questions. Any suspicious answer will be reviewed by the Medical Director of Employee Health at Community Health Network to determine next steps. • Date Started: February 9, 2015 • Date to be Completed: February 18, 2015 • Long Term Remedy: Infection Prevention historically led the TB program at Community Westview. Beginning in April, Employee Health will establish an on-site presence at Community Westview and manage the medical surveillance programs including annual TB screening of all healthcare workers. • Date Started: April 1, 2015 • Date to be Completed: ongoing –annual by birth month • Plan to prevent future recurrence: Follow network policy for annual screening during birth month. ED, Infectious Disease Physicians, and Pulmonary Physicians will be required to complete skin testing; all others will complete the screening questionnaire as long as Community Westview remains a low risk institution for tuberculosis. This will be 		

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S 394 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on review of documents and interview, the governing board failed to ensure that the facility maintained a list of all contracted services for 3 of 11 contracted services and included the nature of the services provided for 11 of 11 contracted services.</p> <p>Findings:</p> <p>1. In interview, on 2-2-15 at 10:00 am, facility staff indicated the facility had</p>	S 394	<p>monitored according to policy by Employee Health.</p> <ul style="list-style-type: none"> Who is responsible for numbers 1 & 2 above? (Not by name, but by position)Employee Health at Community Health Network <p>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.)2/18/15</p> <p>Issue Identified: Based on review of documents and interview, the governing board failed to ensure that the facility maintained a list of all contracted services for 3 of 11 contracted services and included the nature of the services provided for 11 of 11 contracted services.</p> <p>• Short Term Remedy: A listing on contracted services was developed on 2/28/15. • Date Started: 2/11/2015 • Date to be Completed: 2/28/15</p>	02/11/2015

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S 406 Bldg. 00	<p>contracted services for bioengineering, biohazardous waste hauler, blood bank, housekeeping, laundry, medical records, nursing, pharmacy, teleradiology, renal dialysis, and transcription.</p> <p>2. Review of a document listing contracted services, indicated the services of bioengineering, biohazardous waste hauler, blood bank, housekeeping, laundry, medical records, teleradiology, and renal dialysis were not included on the list.</p> <p>3. Further review of the above document indicated it did not include the nature of the services provided.</p> <p>4. In interview, on 2-4-2015 at 2:30 pm, hospital staff confirmed the above and no further documentation was provided prior to exit.</p> <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</p>		<ul style="list-style-type: none"> • Long Term Remedy: The listing of contracted services will be updated as needed, as changes occur. Contracts will be evaluated on an annual basis. • Date Started: 2/11/15 • Date to be Completed: ongoing • Plan to prevent future recurrence: All clinical contracted services will be evaluated per policy. Quality department will ensure that all contracts are evaluated. • Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Quality Supervisor and/ or Regulatory Coordinator • 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.) February 11, 2015 and ongoing 		

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	<p>evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include monitors and standards for 3 services directly-provided by the hospital, 6 services provided by a contractor, and 1 other activity as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the directly-provided services of maintenance, pharmacy, and sleep lab. 2. Review of the facility's QAPI program for calendar year 2014 indicated it did not include monitors and standards for the contracted services of blood bank, housekeeping, medical records, nursing, pharmacy, and transcription. 3. Review of the governing board minutes for calendar year 2013, indicated they did not include review of reports for the activity of medication errors. 	S 406	<p>Issue Identified: Based on document review and interview, the hospital failed to include monitors and standards for 3 services directly-provided by the hospital, 6 services provided by a contractor, and 1 other activity as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2014.</p> <ul style="list-style-type: none"> • Short Term Remedy: The hospital has added the missing directly- provided and contracted services to the quality improvement indicator dashboard. • Date Started: 2/28/2015 • Date to be Completed: ongoing • Long Term Remedy: Quality Supervisor will ensure that services offered to the patients at Community Westview Hospital are reflected in our quality monitoring program. • Date Started: 2/28/2015 • Date to be Completed: ongoing • Plan to prevent future recurrence: Quality Supervisor will ensure that services offered to the patients at Community Westview Hospital are reflected in our quality monitoring program. • Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Quality Supervisor 	03/05/2015

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S 408 Bldg. 00	<p>4. In interview, on 2-4-15 at 10:40 am, employee #A5, Quality Resources network staff, and on 2-4-15 at 2:30 pm, employee #A9, Quality Supervisor, both confirmed all the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</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>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).</p> <p>Based on review of documents and interview, the hospital failed to include the function of medication errors in its quality assurance and improvement (QA&I) program for calendar year 2014.</p>	S 408	<p>• What date will deficiency be corrected? 3/5/15</p> <p>Issue Identified: S408 Quality Assessment and Improvement Based on review of documents and interview, the hospital failed to include the function of medication errors in its quality</p>	02/12/2015

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	<p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's QA&I program for calendar year 2014 indicated it did not report outcomes of medication errors. On 2-5-15 at 2:30 pm, employee #A9, Quality Supervisor, confirmed the above and no further documentation was provided prior to exit. 		<p>assurance and improvement (QA&I) program for calendar year 2014.</p> <p>Review of the Governing Board minutes indicated they did not include review of reports for the activity of medication errors.</p> <ul style="list-style-type: none"> Short Term Remedy: Medication errors will be reported to the Quality/UR/Risk Management Committee as a standing agenda item with documentation provided in the minutes. A quality report including the medication errors activity will be reported at the Medical Executive Committee and reported to the Governing Board. Date Started: 2/12/2015 Date to be Completed: ongoing Long Term Remedy: Medication errors will be reported to the Quality/UR/Risk Management Committee as a standing agenda item with documentation provided in the minutes. A quality report including the medication errors activity will be reported at the Medical Executive Committee and reported to the Governing Board. Date Started: 2/12/2015 Date to be Completed: ongoing Plan to prevent future recurrence: Medication errors will be reported to the Quality/UR/Risk Management Committee as a standing agenda item with documentation provided in the 		

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S 420 Bldg. 00	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the hospital:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p>		<p>minutes. A quality report including the medication errors activity will be reported at the Medical Executive Committee and reported to the Governing Board.</p> <ul style="list-style-type: none"> • Who is responsible for numbers 1 & 2 above? (Not by name, but by position)Quality SupervisorCNO • What date will deficiency be corrected? 2/12/15 	

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	<p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations:</p> <p>(AA) that occur in the course of surgery; or</p> <p>(BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded:</p> <p>(AA) Objects intentionally implanted as part of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p>			

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	<p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug;</p> <p>(BB) dose;</p> <p>(CC) patient;</p> <p>(DD) time;</p> <p>(EE) rate;</p> <p>(FF) preparation; or</p> <p>(GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability</p>			

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	<p>associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a</p>			

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	<p>patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital. (iv) Patient death or serious disability associated with a fall while being cared for in the hospital. (v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital. (F) The following criminal events: (i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider. (ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on the grounds of the hospital. (iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p> <p>Based on document review and interview, the hospital failed to include reportable events as part of its quality assessment and performance improvement (QAPI) program for calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's QAPI program for calendar year 2014 indicated it did not include reportable events. In interview, on 2-4-15 at 2:30 pm, employee #A9, Quality Supervisor, 	S 420	<p>Issue Identified: Based on document review and interview, the hospital failed to include reportable events as part of its quality assessment and performance improvement (QAPI) program for calendar year 2014. • Short Term Remedy: Report of reportable events were be presented at the February Med Executive meeting. To date, there have been ZERO reportable events for 2014 and 2015. • Date Started: 2/17/2015 • Date to be Completed: 2/17/15 • Long Term Remedy: Quality Supervisor will ensure that any reportable events are presented</p>	02/17/2015

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S 554 Bldg. 00	<p>confirmed the above and no documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review, observation and interview, the hospital failed to follow the manufacturer's instructions for using Cidex OPA Solution Test Strips to perform control tests in 1 instance, failed to follow hospital policy to test CIDEX OPA Solution prior to each usage, failed to ensure that patient supplies that were past the manufacturer outdate were removed from inventory in 3 of 6 patient care units and that the wall behind the endoscope processors was free of holes in the drywall.</p>	S 554	<p>to the Med Executive Committee at least 4 times per year. • Date Started: 2/17/2015 • Date to be Completed: ongoing • Plan to prevent future recurrence: Quality Supervisor will ensure that services offered to the patients at Community Westview Hospital are reflected in our quality monitoring program. • Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Quality Supervisor • What date will deficiency be corrected? 2/17/15</p> <p>Issue Identified: S554 Infection Control Based on document review, observation and interview, the hospital failed to follow the manufacturer's instructions for using Cidex OPA Solution Test Strips to perform control tests in 1 instance, failed to follow hospital policy to test CIDEX OPA Solution prior to each usage, failed to ensure that patient supplies that were past the manufacturer outdate were removed from inventory in 3 of 6 patient care units and that the wall behind the endoscope</p>	02/13/2015	

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	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of facility policy RAD-41, entitled Ultrasound Probe Sterilization, effective 09/14, indicated during the 14 days of CIDEX OPA reuse, the CIDEX OPA solution is tested with the Cidex OPA QA test strips prior to each usage. 2. Review of the manufacturer's recommendation on the test strip bottle for Cidex Test Strips, indicated testing of positive and negative controls be performed on each newly opened test strip bottle of CIDEX OPA Solution Test Strips. 3. Review of the log for testing of Cidex OPA, located in the Ultrasound Room, indicated there was no documentation of testing of positive and negative controls on each newly opened bottle of CIDEX OPA Solution Test Strips. 4. In interview, on 2-2-15 at 12:30 pm, an ultrasound staff employee, U1, indicated there was no documentation of this testing and indicated the solution was only tested once per day and not before each usage. No further documentation was provided prior to exit.5. During observations beginning at 10:30 AM on 02/02/15, the following observations were made in the Medical Surgical Unit: 		<p>processors was free of holes in the drywall.</p> <p>Findings:1. Review of facility policy RAD-41, entitled Ultrasound Probe Sterilization, effective 09/14, indicated during the 14 days of CIDEX OPA reuse, the CIDEX OPA solution is tested with theCidex OPA QA test strips prior to each usage.2. Review of the manufacturer's recommendation on the test strip bottle for Cidex Test Strips, indicated testing of positive and negative controls be performed on each newly opened test strip bottle of CIDEX OPA SolutionTest Strips.3. Review of the log for testing of Cidex OPA, located in the Ultrasound Room, indicated there was no documentation of testing of positive and negative controls on each newly opened bottle of CIDEX OPA Solution Test Strips.4. In interview, on 2-2-15 at 12:30 pm, an ultrasound staff employee, U1, indicated there was no documentation of this testing and indicated the solution was only tested once per day and not before each usage. No further documentation was provided prior to exit.</p> <p>Short Term Remedy: Ultrasound technologist were educated on the proper use and testing of the Cidex OPA Test strips (according to manufacturer's guidelines). • Date Started: 02/02/2015• Date to be Completed:</p>	

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	<p>(a) In room 320, an Infovac had an expiration date of 01/15 and a Vac Veraflo had an expiration date of 12/14.</p> <p>6. During observations beginning at 11:15 AM on 02/02/15, the following observation was made in the Progressive Care Unit:</p> <p>(a) In the clean utility room a Temporary Pacing device had an expiration date of 02/09.</p> <p>(b) In the clean utility room a box with blood collection tubes(blue top, red top, yellow top, lavender top and green top) were all expired.</p> <p>7. During observations beginning at 11:30 AM on 02/02/15, the following observations were made in the Emergency Department:</p> <p>(a) In the Pediatric cart 1 Suction Catheter tray had expiration dates of 11/14.</p> <p>8. During observations beginning at 9:30 AM on 02/03/15, the following observations were made in the Surgery Department:</p> <p>(a) The wall behind the Steris System endoscope processor had a hole in the drywall.</p>		<p>02/03/2015 Long Term Remedy: All Ultrasound technologist will be evaluated on an annual basis to determine competency in the use and testing of the Cidex OPA test strips (according to manufacturer's guidelines). This evaluation will be documented to ensure compliance. Retraining will be provided as needed. • Date Started: 02/02/2015• Date to be Completed: Ongoing Plan to prevent future recurrence: Compliance will be monitored at least monthly. Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Manager and US technologist/s 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.) The deficiency was corrected on 02.03.2015 Issue Identified: S554 Infection Control Based on document review, observation and interview, the hospital failed to follow the manufacturer's instructions for using Cidex OPA Solution Test Strips to perform control tests in 1 instance, failed to follow hospital policy to test CIDEX OPA Solution prior to each usage, failed to ensure that patient supplies that were past the manufacturer outdate were removed from inventory in 3 of 6</p>	

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			<p>patient care units and that the wall behind the endoscope processors was free of holes in the drywall.</p> <p>Findings:6. During observations beginning at 11:15 AM on 02/02/15, the following observation was made in the Progressive Care Unit: (a) In the clean utility room a Temporary Pacing device had an expiration date of 02/09. (b) In the clean utility room a box with blood collection tubes (blue top, red top, yellow top, lavender top and green top) were all expired.</p> <p>7. During observations beginning at 11:30 AM on 02/02/15, the following observations were made in the Emergency Department:(a) In the Pediatric cart 1 Suction Catheter tray had expiration dates of 11/14.</p> <p>Short Term Remedy: The outdated items were removed from the respective areas by the Unit Manager at the time of the survey.</p> <p>• Date Started: 02/02/2015• Date to be Completed: 02/02/2015</p> <p>Long Term Remedy: Supplies will be audited by assigned staff at least quarterly to ensure no outdated supplies are in use. Any supplies found to outdate within that quarter will be removed from supply area and given to manager.</p> <p>• Date Started: 02/16/2015• Date to be Completed: Ongoing Plan to prevent future recurrence:</p>	

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			<p>Supplies will be audited at least quarterly to ensure no outdated supplies are in use. Any supplies found to outdate within that quarter will be removed from supply area and given to manager. The manager will also do random spot checks several times per month to ensure compliance and to make sure that there are no outdated items present.</p> <p>Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Assigned staff and management</p> <p>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.) 02/02/2015</p> <p>Issue Identified: S554 Infection Control</p> <p>Based on document review, observation and interview, the hospital failed to follow the manufacturer's instructions for using Cidex OPA Solution Test Strips to perform control tests in 1 instance, failed to follow hospital policy to test CIDEX OPA Solution prior to each usage, failed to ensure that patient supplies that were past the manufacturer outdate were removed from inventory in 3 of 6 patient care units and that the wall behind the endoscope processors was free of holes in the drywall.</p>	

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			<p>Findings: During observations beginning at 9:30 AM on 02/03/15, the following observations were made in the Surgery Department: (a) The wall behind the Steris System endoscope processor had a hole in the drywall</p> <p>Short Term Remedy: The holes found in the wall in Surgery Department will be patched immediately.</p> <p>• Date Started: 02/03/2015• Date to be Completed: 02/13/2015</p> <p>Long Term Remedy: Environmental rounds will be conducted on an ongoing basis in the Surgery Department, any new holes found will be reported and repaired immediately.</p> <p>• Date Started: 02/03/2015• Date to be Completed: Ongoing</p> <p>Plan to prevent future recurrence: Environmental rounds will be conducted on an ongoing basis in the Surgery Department, any new holes found will be reported and repaired immediately.</p> <p>Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Surgery Manager and Facilities Supervisor</p> <p>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.)</p>	

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S 668 Bldg. 00	<p>410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(c)</p> <p>(c) The medical staff and a pathologist shall determine which tissue specimens require a macroscopic examination only and which require both macroscopic and microscopic examinations. Categories of specimens removed during surgical procedures which are determined to require only macroscopic examination shall be specified in the laboratory policies and the medical staff rules. The medical staff and a pathologist shall determine the qualified licensed health professional responsible for macroscopic examination. Based on document review and interview, the medical staff and pathologist failed to determine which tissue specimens require a macroscopic exam only and which require both a macroscopic and microscopic exam.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the medical staff rules and regulations indicated the Indiana State Department of Health requires certain tissues be examined by the Pathology Department for gross examination. On 2-4-2015 at 1:15 pm facility staff was requested to provide documentation 	S 668	<p>02/13/2015</p> <p>Issue Identified: S668 Laboratory Services Based on document review and interview, the medical staff and pathologist failed to determine which tissue specimens require a macroscopic exam only and which require both a macroscopic and microscopic exam. Short Term Remedy: At the time of survey, staff was unable to locate requested documentation. Ameripath policy DID exist at the time of survey, however, staff was unaware of its location and how to find it. Staff was educated on location and content of such documentation. • Date Started: 02/06/2015 Date to be Completed: 02/06/2015</p>	03/02/2015

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S 732 Bldg. 00	of the above-stated requirements and no documentation was provided prior to exit. 410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4) (d) The medical record shall contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results. Based on policy review, medical record review and interview, the facility failed to	S 732	Long Term Remedy: All staff will be educated in team meeting on the policies and procedures associated with handling of specimen. Policy made available to pathology staff. • Date Started: 03/01/2015 • Date to be Completed: Ongoing Plan to prevent future recurrence: All staff will be educated in team meeting on the policies and procedures associated with handling of specimen. Policy made available to pathology staff. Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Lab Supervisor, Community Westview 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.) 03/02/2015 Issue Identified: S732	02/05/2015	

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	<p>ensure that transfer consent was obtained on 1 (#3) of 3 medical records.</p> <p>Findings:</p> <p>1. Review of policy and procedure, ER 67800 - 0020 "Transfer of Patients" last revised on 06/2014 indicated:</p> <p>a. Under attachment "Discharge Procedures", II. Patient transferring to another Hospital,</p> <p>c. Complete Flow Chart. Flow chart indicates that a consent for transfer is to be completed prior to transfer.</p> <p>2. Medical record review indicated the following:</p> <p>a. There was no evidence of consent for transfer in medical record # 3.</p> <p>3. At 11:00 am on 2/04/15, staff member #A10 verified that a transfer consent was not in the above medical record.</p>		<p>Medical Records</p> <p>Based on policy review, medical record review and interview, the facility failed to ensure that transfer consent was obtained on 1 (#3) of 3 medical records.</p> <p>-</p> <p>-</p> <p>Short Term Remedy:</p> <p>Nursing staff re-educated on the procedures to be followed in the transfer of a patient (whether internal or external). Procedure outlined and documented & presented. A copy of this procedure is now located in Nursing Supervisor Information Binder.</p> <p>· Date Started: 02/05/2015</p> <p>· Date to be Completed: 02/05/2015</p> <p>-</p> <p>Long Term Remedy:</p>	

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			<p>-</p> <p>All staff educated in team meeting on the procedures associated with transferring a patient (whether internal or external). Internal auditing will be performed by nursing supervisor and reported to CNO monthly for 6 months.</p> <p>· Date Started: 02/06/2015</p> <p>· Date to be Completed: Ongoing</p> <p>-</p> <p><u>Plan to prevent future recurrence:</u></p> <p>All staff educated in team meeting on the procedures associated with transferring a patient (whether internal or external). Patient Transfer instruction form modified to include the "patient signature requirement". A copy of this procedure is now located in Nursing Supervisor Information Binder. Internal auditing will be performed by nursing supervisor and reported to CNO monthly for 6 months.</p>	

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S 804 Bldg. 00	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1) (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		Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Nursing Supervisor Regulatory Assistant 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.) 02/05/2015	

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	<p>governing board and do the following:</p> <p>(1) Conduct outcome oriented performance evaluations of its members at least biennially.</p> <p>Based on document review and interview, the facility failed to document outcome oriented performance evaluation, at least biennially, for 3 (MD#1, MD#2 and MD#3) of 3 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 3 medical staff credential files indicated files MD#1, hospitalist, MD#2, emergency department, and MD#3, teleradiologist, had no documentation of biennial outcome oriented performance evaluation.</p> <p>2. In interview, on 2-3-2015 at 2:20 pm, employee #A5, Quality Resources network staff, indicated the review had been performed but the documentation was unable to be located and no other documentation was provided prior to exit.</p>	S 804	<p>Issue Identified: S804 Medical Staff</p> <p>Based on document review and interview, the facility failed to document outcome oriented performance evaluation at least biennially for 3 (MD#1, MD#2 and MD#3) of 3 medical staff credential files reviewed.</p> <p>At the time of the ISDH survey, Community Westview was accredited by HFAP. Ongoing Physician Performance Evaluation (OPPE) was not a requirement for HFAP accreditation. HFAP required only that physician performance be evaluated biennially. <u>This was, in fact, completed on all physicians credentialed to practice at Community Westview.</u> There</p>	03/04/2015

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			<p>was confusion in regards to exactly what the surveyor was asking for, so the incorrect answer was given. Physician performance was evaluated every 2 years as required by HFAP, but there had not been OPPE completed, as would have been required by TJC.</p> <p>As of January 1, 2015, HFAP requires that the Medical Staff is required to develop a process for the ongoing evaluation of all practitioners that have been granted privileges by the Governing Body. A task force was developed in January 2015 at Community Westview Hospital to address the ongoing review of Physician's Performance and upcoming move to Joint Commission accreditation. Process implemented to start physician performance data collection.</p> <p>· Date Started: 02/06/2015</p> <p>· Date to be Completed: Ongoing</p>	

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S 840	410 IAC 15-1.5-5		<p>-</p> <p>Currently there are 218 active physicians at Community Westview. This task force is developing a plan to complete OPPE on an ongoing basis. The performance of all Physicians will be reviewed by the Medical Staff Services during their designated birth month as per regulatory standards.</p> <p>· <u>Who is responsible for numbers 1 & 2 above?</u> (Not by name, but by position) Quality Supervisor</p> <p>Medical Staff Services Personnel</p> <p>Regulatory Assistant</p> <p>· <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.)</p> <p>03/04/2015 and ongoing</p>	

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Bldg. 00	<p>MEDICAL STAFF 410 IAC 15-1.5-5 (b)(2)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(2) be reviewed at least triennially; and Based on document review and interview, the medical staff failed to review the medical staff rules according to facility policy.</p> <p>Findings:</p> <p>1. Review of facility policy SPP NO: A-1, entitled INSTRUCTIONS FOR ADMINISTRATION POLICIES AND PROCEDURES, revised 12/14, indicated policies and procedures should be reviewed biennially and revised as necessary.</p> <p>2. On 2-2-15 at 10:00 am, employee #A2, ER-PCU Manager, was requested to provide documentation the governing board had approved of the medical staff rules within the last 2 years</p> <p>3. In interview, on 2-4-2015 at 2:10 pm, employee #A5, Quality Resources staff, indicated there was no documentation and none was provided prior to exit.</p>	S 840	<p>Issue Identified: S840 Medical Staff</p> <p>Based on document review and interview, the medical staff failed to review the medical staff rules according to facility policy.</p> <p>Findings:1. Review of facility policy SPP NO: A-1, entitled INSTRUCTIONS FOR ADMINISTRATION POLICIES AND PROCEDURES, revised 12/14, indicated policies and procedures should be reviewed biennially and revised as necessary.2. On 2-2-15 at 10:00 am, employee #A2, ER-PCU Manager, was requested to provide documentation the governing board had approved of the medical staff rules within the last 2 years.3. In interview, on 2-4-2015 at 2:10 pm, employee #A5, Quality Resources staff, indicated there was no documentation and none was provided prior to exit.</p> <p>Short Term Remedy: At the time of the survey interview a Community Westview Employee was unable to provide documentation to support that the medical staff rules had indeed</p>	02/06/2015

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			<p>been reviewed during. Meeting minutes from the Annual Professional Staff Meeting on 10/14/2014 indicate that changes to the Medical Staff Bylaws/ Rules and Regulations were reviewed for approval. Staff was educated on location and content of such documentation.</p> <ul style="list-style-type: none"> • Date Started: 02/06/2015 • Date to be Completed: Ongoing <p>Long Term Remedy: Staff re-educated on location of documentation related to review of the Medical Staff rules, regulations and bylaws. Documentation made available to pertinent staff. Medical Staff Office will bring Bylaws/ Rules & Regulations to Medical Executive meetings for review and approval prior to biennial anniversary.</p> <ul style="list-style-type: none"> • Date Started: 02/06/2015 • Date to be Completed: Ongoing <p>Plan to prevent future recurrence: Staff re-educated on location of documentation related to review of the Medical Staff rules, regulations and bylaws. Documentation made available to pertinent staff. Electronic copy of related documentation and hard copy of documentation will be housed in the Medical Staff Offices and the Quality Improvement Office. Medical Staff Office will bring Bylaws/ Rules & Regulations to Medical Executive meetings for review and approval prior to biennial anniversary.</p> <p>Who is responsible for numbers 1</p>	

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S 952 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, transfusion record review, and interview, the facility failed to follow approved medical staff policies/procedures for 6 of 6 transfusions reviewed.</p> <p>Findings include: 1. A policy/procedure titled: "Blood-Starting Blood For Transfusion, Effective: 05-77, Revised: 04-12" which states: "B. An RN will obtain pre-transfusion vital signs.....and obtain</p>	S 952	<p>& 2 above? (Not by name, but by position) Quality Supervisor Medical Staff Services Personnel Regulatory Assistant 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.) 02/06/2015 and Ongoing</p> <p>Issue Identified: S 952 Nursing Service</p> <p>This RULE is not met as evidenced by:</p> <p>Based on policy/procedure review, transfusion record</p>	03/02/2015

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	<p>15 minute transfusion vital signs. N. Assess patient status and obtain vital signs (blood pressure, pulse and respirations) every thirty minutes during the transfusion and immediately after completion of transfusion. "</p> <p>2. Transfusion record review demonstrated T#1, T#2, T#3, T#4, #6, had the previtals done the same time transfusions started, none of the 6 transfusions had vitals taken every thirty minutes during the transfusions.</p> <p>3. In interview at 3:15 p.m. on 2/3/15 SP (staff persons) #3 and #4 acknowledged the approved medical staff policy/procedure was not followed.</p>		<p>review, and interview, the facility failed to follow approved medical staff policies/procedures for 6 of 6 transfusions reviewed.</p> <p>Findings include:</p> <p>1. A policy/procedure titled: "Blood-Starting Blood For Transfusion, Effective: 05-77, Revised: 04-12" which states: "B. An RN will obtain pre-transfusion vital signs.....and obtain 15 minute Transfusion vital signs. N. Assess patient status and obtain vital signs (blood pressure, pulse and respirations) every thirty minutes during the transfusion and immediately after completion of transfusion. "</p> <p>2. Transfusion record review demonstrated T#1, T#2, T#3, T#4, #6, had the previtals done the same time transfusions started, none of the 6 transfusions had vitals taken every thirty minutes during the transfusions.</p> <p>3. In interview at 3:15 p.m. on</p>	

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			<p>2/3/15 SP (staff persons) #3 and #4 acknowledged the approved</p> <p>Medical staff policy/procedure was not followed</p> <p>-</p> <p>Short Term Remedy:</p> <p>Policy modified to reflect the need for pre-transfusion vital signs to be completed prior to start of transfusion and documentation of transfusion vital signs every 30 minutes during the blood transfusion. Education provided to staff regarding policy modifications and requirements for blood transfusion policy.</p> <p>· Date Started: 02/09/2015</p> <p>· Date to be Completed: 03/02/2015</p> <p>-</p> <p>Long Term Remedy:</p> <p>As new staff are onboarded, they will receive education on blood transfusions. All staff that administer blood complete an annual competency on blood administration. Ongoing education to be provided as Community Westview Hospital continues</p>	

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			<p>transition to Community Health Network policies. Internal auditing will be performed by nursing supervisor and reported to CNO monthly for 6 months.</p> <p>· Date Started: 02/09/2015</p> <p>· Date to be Completed: 07/01/2015</p> <p>-</p> <p><u>Plan to prevent future recurrence:</u></p> <p>Once integration into the Community Health Network system nears completion, re-education will occur a second time to ensure that policies and procedures are followed as written. Internal auditing will be performed by nursing supervisor and reported to CNO monthly for 6 months.</p> <p><u>Who is responsible for numbers 1 & 2 above?</u> (Not by name, but by position) Community Westview Nurse Educator</p> <p>Clinical Nurse Specialist</p> <p>Regulatory Assistant</p>	

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S 118 Bldg. 00	<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 and interview, the facility failed to ensure that the temperature of 1 blanket warmer did not exceed the maximum temperature for fluids warming.</p> <p>Findings:</p> <p>1. During observations beginning at 9:30</p>	S 118	<p><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.)</p> <p>03/02/2015 and Ongoing</p> <p><u>Issue Identified:</u> S1118 Physical Plant</p> <p>This RULE is not met as evidenced by: S1118</p>	02/15/2015

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	<p>AM on 02/02/15, the following observations were made in the Surgery Unit:</p> <p>(a) In scope room in the surgery sub-sterile area the blanket warmer had two compartments. The upper compartment had bottles of fluid. The temperature reading for the upper compartment was 116.4 degrees. The lower compartment temperature reading did not display a temperature.</p> <p>2. Interview with staff #A3 verified that the maximum temperature for the blanket warmer is 105 degrees. He/she also verified that there is no policy for monitoring the blanket warmer.</p>		<p>Based on observation and interview, the facility failed to ensure that the temperature of 1 blanket warmer did not exceed the maximum temperature for fluids warming.</p> <p>-</p> <p>1. During observations beginning at 9:30 AM on 02/02/15, the following observations were made in the Surgery Unit: (a) In scope room in the surgery sub-sterile area the blanket warmer had two compartments. The upper compartment had bottles of fluid. The temperature reading for the upper compartment was 116.4 degrees. The lower compartment temperature reading did not display a temperature.</p> <p>2. Interview with staff #A3 verified that the maximum temperature for the blanket warmer is 105 degrees. He/she also verified that there is no policy for monitoring the blanket warmer.</p> <p>-</p> <p>Short Term Remedy:</p>	

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			<p>-</p> <p>Review of AORN standard yielded the blanket temp should be no higher than 130 degrees and a review of the manufacturer information for the fluid yielded that the fluid should be no higher than 104 degrees. A procedure and log sheet have been developed and put in place and new labels have been created with the corrected information placed on the warmers.</p> <p>BioMed called to check the warmer and fix thermometer.</p> <p>-</p> <p>Date Started: 02/03/2015</p> <p>-</p> <p>Date to be Completed: 02/15/15</p> <p>-</p> <p><u>Plan to prevent future recurrence:</u></p> <p>A procedure and log sheet have been developed and put in place and new labels have been created with the corrected information placed on the warmers. Will keep</p>	

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			<p>information contained in log current at all times. BioMed scheduled to provide service and ongoing maintenance for the unit. Checks to be performed daily and documented on log sheet by surgery staff. This will be reviewed monthly by facilities department for 6 months.</p> <p>· Date Started: 02/2015</p> <p>· Date to be Completed: ongoing</p> <p><u>Who is responsible for numbers 1 & 2 above?</u> (Not by name, but by position)</p> <p>Director of Surgery Services</p> <p><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.)</p>	

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S 164 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT</p> <p>410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM) for 1 piece of equioment.</p> <p>Findings:</p> <p>1. Review of a PM document for the Sleep system indicated the Inspection Schedule was Evidence Based - No Schedule.</p> <p>2. Review of an e-mail dated 2-3-15 from a contracted biomedical engineering representative to the facility indicated the Sleep system is not categorized as a critical device and there is no history of maintenance preventable failures, or failures of any kind, so the</p>	S 164	<p>02/15/2015 and ongoing</p> <p>Issue Identified: S1164 Physical Plant Based on document review and interview, the facility failed to provide evidence of preventivemaintenance (PM) for 1 piece of equipment.Findings:1. Review of a PM document for the Sleep system indicated the Inspection Schedule wasEvidence Based - No Schedule.2. Review of an e-mail dated 2-3-15 from a contracted biomedical engineering representativeto the facility indicated the Sleep system is not categorized as a critical device and there is nohistory of maintenance preventable failures, or failures of any kind, so the current InspectionSchedule is Evidence Based - No Schedule. 3. On 2-4-15 at 1:30 pm, employee #A4, Facilities</p>	02/06/2015

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	<p>current Inspection Schedule is Evidence Based - No Schedule.</p> <p>3. On 2-4-15 at 1:30 pm, employee #A4, Facilities Supervisor, was requested to provide documentation of a waiver from the State which indicated the facility could use a system to categorize equipment for PM in lieu of periodic (annual) PM activity or following manufacturer's recommendations.</p> <p>4. In interview, on 2-4-15 at 3:00 pm, employee #A4 indicated the facility was not able to provide documentation of the above-described waiver and no other documentation was provided prior to exit.</p>		<p>Supervisor, was requested to providedocumentation of a waiver from the State which indicated the facility could use a system to categorize equipment for PM in lieu of periodic (annual) PM activity or following manufacturer's recommendations.</p> <p>4. In interview, on 2-4-15 at 3:00 pm, employee #A4 indicated the facility was not able to providedocumentation of the above-described waiver and no other documentation was provided prior toexit.</p> <p>Short Term Remedy: Items with no evidence of PM were protected under a Waiver provided by the ISDH. At time of survey, waiver DID exist, however, staff was unable to locate. A copy of the ISDH waiver was located and staff educated on the contents and purpose of said waiver.</p> <p>• Date Started: 2/3/2015• Date to be Completed: 2/6/2015</p> <p>Long Term Remedy: Ensure that an electronic copy of the Waiver is accessible at all times. Original copies will be housed in the facilities area.</p> <p>• Date Started: 2/5/2015• Date to be Completed: Ongoing</p> <p>Plan to prevent future recurrence:Facilities Supervisor/ Staff will monitor and ensure that all required documents are available and current.Who is responsible for numbers 1 & 2 above? (Not by name, but by position)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150129	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY WESTVIEW HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3630 GUION RD INDIANAPOLIS, IN 46222
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S 166 Bldg. 00	<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. Based on interview, the facility failed to provide documentation of current leakage check on 1 piece of equipment.</p> <p>Findings: 1.. On 2-2-15 at 10:30 am, employee #A4 was requested to provide documentation of a current leakage check for an adult bed. No documentation was provided prior to exit.</p>	S 166	<p>Facilities 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.) The deficiency was corrected on 2/6/2015.</p> <p>Issue Identified: S 1166 Physical Plant Based on interview, the facility failed to provide documentation of current leakage check on 1piece of equipment. Findings:1. On 2-2-15 at 10:30 am, employee #A4 was requested to provide documentation of a currentleakage check for an adult bed. No documentation was provided prior to exit. Short Term Remedy: Voltage leakage testing was conducted on all beds that are currently in use</p>	02/16/2015

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NAME OF PROVIDER OR SUPPLIER COMMUNITY WESTVIEW HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3630 GUION RD INDIANAPOLIS, IN 46222		
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S 168 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows:		at Community Westview Hospital. • Date Started: 02/09/2015• Date to be Completed: 02/17/2015 Long Term Remedy: All beds that are currently in use at Community Westview Hospital have been placed on schedule for ongoing routine maintenance. All newly acquired beds will be monitored and included in the ongoing maintenance schedule. • Date Started: 2/5/2015• Date to be Completed: Ongoing Plan to prevent future recurrence: All beds that are currently in use at Community Westview Hospital have been placed on schedule for ongoing routine maintenance. All newly acquired beds will be monitored and included in the ongoing maintenance schedule. Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Facilities 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.) The deficiency was corrected on 2/16/2015.		

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NAME OF PROVIDER OR SUPPLIER COMMUNITY WESTVIEW HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3630 GUION RD INDIANAPOLIS, IN 46222		
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	<p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the facility failed to follow its policy to complete daily the testing of 1 defibrillator.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a document entitled LIFEPAK 20 INSTRUCTIONS, dated Feb 2015, for a defibrillator located in the Stress Lab, indicated [staff was to] Complete Daily the Defibrillator/Monitor Operator's Checklist/user Test. Review of the above-stated documents for the months of August, 2014 through January, 2015, indicated there was no documentation for completion of the document for September, 2014. On 2-2-2015 at 1:00 pm, facility staff was requested to provide documentation for the month of September, 2014 and no documentation was provided prior to exit. 	S 168	<p>Issue Identified: S1168 Physical Plant</p> <p>Based on document review and interview, the facility failed to follow its policy to complete dailythe testing of 1 defibrillator.</p> <p>Findings:1. Review of a document entitled LIFEPAK 20 INSTRUCTIONS, dated Feb 2015, for a defibrillator located in the Stress Lab, indicated [staff was to] Complete Daily the Defibrillator/Monitor Operator's Checklist/user Test.</p> <p>2. Review of the above-stated documents for the months of August, 2014 through January, 2015, indicated there was no documentation for completion of the document for September, 2014.</p> <p>3. On 2-2-2015 at 1:00 pm, facility staff was requested to provide documentation for the month of September, 2014 and no documentation was provided prior to exit. Short Term Remedy:Education provided to staff regarding proper documentation of daily code cart checks. Data collected for September 2014 was incorrectly recorded on the back of the log for August 2014. This information was transferred to the proper data collection form and archived.</p> <p>• Date Started: 02/03/2015•</p>	02/09/2015	

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			<p>Date to be Completed: 03/03/2015</p> <p>Long Term Remedy: Policy regarding checking of the Code Cart was modified to include information specific to areas that do not provide 24 hour care. Staff educated on the changes. As new staff are onboarded, they will receive this education. Leader of area will conduct a monthly audit to ensure compliance. • Date Started: 03/02/2015• Date to be Completed: Ongoing</p> <p>Plan to prevent future recurrence:Policy regarding checking of the Code Cart was modified to include information specific to areas that do not provide 24 hour care. Staff educated on the changes. Leader of area will conduct a monthly audit to ensure compliance.</p> <p>Who is responsible for numbers 1 & 2 above? (Not by name, but by position) Nurse EducatorDepartment Leaders</p> <p>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.) 02/09/2015 and ongoing</p>	