

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150128	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005109</p> <p>Survey Date: 05/20-22/13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 05/29/13</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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S000270	<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 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 reports of quality monitoring activities for 1 contracted service.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the governing board minutes for calendar year 2012, indicated they did not include review of reports for the contracted tissue transplant services. 2. In interview, on 5-22-13 at 3:45 pm, employee #A6 confirmed the above and no further documentation was provided prior to exit. 	S000270	<p>Our current process with tissues that are implanted is to log them into our Tissue Tracking Log book. Through Risk Management we receive product recalls that we follow up within the department. These recalls are sent to us by Administrative Secretary for Quality Resources. The Clinical director is responsible for following up on these recalls and sending them back to the secretary so that she has those file for the Network. Locally, when there is a recall on tissue, and it has been implanted in a patient, this is reported to the Director of Pathology. We have not had any product recalls to report but will incorporate this into the infection prevention meetings on a quarterly basis. Next meeting is August 28th, 2013. Events from the Infection Prevention meeting are then</p>	08/28/2013	

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			reported to the Medical Executive Committee, which meets monthly. This process will occur under the direction of Clinical Director of surgical services.	

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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. 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 6 of 10 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of facility medical staff policy indicated those medical staff members who were required to have BLS, ACLS and PALS. However, the policy did not state for any other members of the medical staff what constituted competency for them.</p>	S000318	<p>On June 11th, 2013, the Med Exec committee met to review the CPR policy that was revised by the Medical Staff Office following the annual survey. The changes were voted upon, and approved by the Med Exec committee. Outstanding MD's that fall into the requirement of needing CPR certification, will be reviewed in the Credials committee, and the MD's will be informed that per policy, they are required to have this certification to practice at Community Hospital South. Here is the revised policy:It is the policy of Community Hospitals of Indiana, Inc. that in every case where a person is found without respiration or heartbeat a</p>	06/11/2013			

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	<p>2. Review of 10 medical staff credential files indicated files MD#4, MD#5, MD#7, MD#8, MD#9, and MD#10 did not have any documentation of CPR competency in accordance with current standards of practice and hospital policy.</p> <p>3. In interview, on 5-22-13 at 12:15 pm, employee #A11 confirmed the files contained no documentation of what constituted competency for the above medical staff members and no other documentation was provided prior to exit.</p>		<p>physician qualified to administer CPR will be available to render that care. Members of the Medical Staffs who have direct patient care contact from time to time encounter a patient in cardiac arrest or near cardiac arrest. The nature of medicine is such that certain specialties such as anesthesiology, emergency medicine, and critical care, as well as the family medicine residents more commonly encounter cardiac or near cardiac arrests. Emergency Medicine physicians are required to attend all Code Blues (situations requiring CPR) that occur in the Emergency Departments. It is our position, along with the American College of Emergency Physicians, that Emergency Medicine physicians maintaining an active practice in their field of specialty along with current board certification is adequate demonstration of ongoing competency to deliver CPR. Those physicians who are not board certified demonstrate their competency by current ACLS certification. Should a code blue occur in the operating rooms, the Anesthesiologists are required to attend the Code Blues. Anesthesiologists demonstrate their competency in CPR by sustaining an active practice in their field of specialty and by the very nature of the specialty which undergoes ongoing peer review as per our peer review policies. At</p>		

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			Community Hospital South, Inpatient Services of Indiana (ISI) is responsible for attending all Code Blues that occur within the facility (excluding the Emergency Department, Operating Rooms, Pediatrics and Newborn Nursery). All members of ISI are required to be certified in ACLS. Competency is demonstrated by maintaining current ACLS certification, as well as through ongoing quality review processes. Many of our other physicians maintain competence in CPR, but this is not a requirement. When present, any attending physician may initiate and perform CPR and related resuscitation activities in conjunction with those qualified physicians listed above. In any case, the presence of a qualified physician is assured. In every case, ongoing peer review and performance improvement is mandated. This review is conducted by the Medical Staff Office Specialist during the recertification process.		

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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 hospital failed to include monitors and standards for 1 service directly-provided by the hospital and 6 services provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the directly-provided service of post-operative recovery and the contracted services of audiology, extracorporeal shock wave lithotripsy, massage therapy, magnetic resonance imaging (MRI), PET Scan, and ultrasound.</p>	S000406	Multiple owners are responsible for the following QI indicators. These indicators will be added to the electronic indicator report (this report was shared with the surveyor during the survey).PACU: Director of Surgical Services, along with Director and Manager of Network surgical Services, who are responsible for SCIP indicators.Audiology: After the survey, during review of contracts, it was found that Audiology is offered as an Outpatient service. Patients will be given a referral for this service at discharge.Lithotripsy: In the Pre-Op/Recovery area quality care is being measured by the Surgical Care Improvement Project (SCIP). A randomized sample of patients is gathered by Director and Manager of Network Surgical Services. . The following	07/01/2013			

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	2. In interview, on 5-22-13 at 3:45 pm, employee #A6 confirmed the above and no further documentation was provided prior to exit.		measures are tracked within the department: patients on Beta Blockers must receive Beta Blocker within 24 hours of perioperative period, proper antibiotic selection and timing, and patient warming. Massage: Massage is offered every Tuesday and Thursday by our contracted service, to Joint Replacment patients. A Quality Indicator is being added to the electronic QI report with monitoring of how many massages are completed versus total number of patients each month. MRI: Verification of completeness of exam; adherence to protocols and diagnostic quality of images is being added to the electronic QI report. The target goal for this indicator is 98-98.4% with the current range being 97.5-97.9%. This data has been monitored, but not recorded on the report that the surveyor reviewed. This process is owned by Vickie Hite, manager for Imaging services. PET: Document schedule utilization of Mobile PET scanner is being added to the electronic QI report. The current number of exams completed is in the 87-90 range, with the target goal of 90.1-94. This data has been monitored, but not recorded on the report that the surveyor reviewed. This process is owned by Vickie Hite, manager for Imaging services. Ultrasound: Verification of completeness of		

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			exam; adherence to protocols and diagnostic quality of images is being added to the electronic QI indicator report. The current range is 98.5-98.75% with the target goal of 98.76-99%. This data has been monitored, but not recorded on the report that the surveyor reviewed. This process is owned by Vickei Hite, manager of Imaging services.	

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S000554	<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. Based on document review and observation, the facility did not provide a safe and healthful environment in 2 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of policy DPP NO: US-3, entitled MEDIAL IMAGING STANDARDS FOR CLEANING, DISINFECTING AND DRYING THE INTRAVAGINAL AND/OR INTRACAVITY PROBES, revised 09/11. indicated This testing [of the Cidex disinfectant solution] is also to be done prior to each time a probe is placed in the disinfectant solution. Review of the manufacturer's instructions on the container of the Cidex solution indicated use CIDEX OPA Solution Test Strips to monitor ortho-phthalaldehyde concentration before each use. In interview, on 5-20-13 at 11:55 am, an ultrasound staff member indicated 	S000554	<p>Education was done with the staff on Hospital policy US-3 stating CIDEX testing done prior to each time US probe is placed in solution. This was done by Vickie Hite, manager of Imaging services. A new log was created for documentation on CIDEX testing and communicated with staff. (completed 5/28/31). This was also rolled out and implemented by Vickie Hite, manager of Imaging services. Assigned weekly cleaning of gantry to CT staff (completed 6/11/13) by manager of Imaging services. This process will be monitored during monthly rounding by the manager of Imaging Services.</p>	06/11/2013

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	<p>Cidex solution testing was done once per day, even if the solution was used 2 or more times a day. By not following facility policy, the hospital could not ensure the solution was effective each time if it was used multiple times per day.</p> <p>4. On 5-20-13 at 12:05 pm in the presence of employee #A3, it was observed in the CT Scanner room there were clumps of dust on the CT Scanner. These clumps were located directly above the area where the patient exams occurred.</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, document review, and interview, the facility failed to implement its policy regarding storage conditions in sterile/clean storage rooms on 2 of 11 units toured (Interventional Radiology and Surgical Services).</p> <p>Findings included:</p> <p>1. During tour of the facility on 5-21-2013, in the presence of A3, two (2) sterile/clean storage rooms in the Interventional Radiology unit (IR) contained sterile supplies which were stored in corrugated cardboard boxes; in the presence of A5, a Surgical Services (SS) sterile/clean storage room contained 2 corrugated cardboard boxes which were empty but were stored in the presence of</p>	S000592	<p>For Surgical Services Plan of Corection in Clean Storage Room: The two storage boxes contained instrument sets that were being assembled. Staff have been educated that cardboard boxes should not be kept in the presence of sterile supply and/or out of the OR. Reinforcement of this education will occur on 6/19/2013 which is the next staff meeting for Surgery Staff. The boxes were removed from this area on 5/19/13. Ongoing education and employee rounding will occur by Clinical Director of surgical services, and Team Lead for surgical services. For IR Department: Staff meeting with IR department was held and we reiterated guidelines for corrugated boxes. (Completed</p>	05/22/2013			

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	sterile supplies. 2. Facility policy "Infection Prevention Policy for Materials Management/Central Supply/Supply Processing", last reviewed/revised 1-2013, provided on page 1, A. c. "Outer shipping cartons should not be present where sterile products are stored and issued". 3. During interview with A3 on 5-21-13 at approximately 11:35 AM, A3 indicated: a. staff have been trained not to allow corrugated cardboard boxes in areas where sterile supplies are stored or issued. b. the IR and SS units should not have corrugated boxes stored in the presence of sterile supplies to reduce the risk of infection control issues.		6/10/13). Complete understanding of all staff as the proper type of storage containers to be used for supplies. (Review of Infection Control Policy). Ongoing rounding will occur to ensure this does not happen again by Manager of Medical Imaging.	

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, document review, and interview, the facility failed to assure cleaning and disinfection of point of care glucose testing docking stations (2 of 11 units toured- Emergency Department and Obstetrics) and the facility failed to assure microwave ovens used for patient nutrition were cleaned of food debris to reduce the risk of infection transmission (3 of 11 units toured- 3 South, 4 South, and Progressive Care).</p> <p>Findings included:</p> <p>1. During tour of the facility on 5-20-13, in the presence of A9, the Roche Accu-Chek docking station wells for the point of care glucose testing meters on the Obstetrics unit and the Emergency</p>	S000596	<p>On 6/11/13, an SBAR was distributed to all leadership at CHS to re-educate the cleaning instructions for the Accucheck monitor base. Posters were placed above each unit with a "don't forget" message for cleaning, instructions were posted, and a log was created for all units that cleaning will be done and documented at the same time as the quality controls are run. This was voted and agreed upon by the leadership team on 6/11/13. Here is the SBAR that was distributed by Infection Preventionist with the plan of correction:Recommendation:</p> <ol style="list-style-type: none"> 1. If the base or accessory box is taken into the patient room or visibly soiled it should be cleaned. 2. Once a week during a daily quality control testing the base 	06/11/2013	

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	<p>Department were observed to be soiled with hair, dust, other debris, and a dried red-brown substance that appeared to be blood.</p> <p>2. During tour of the facility on 5-20-13, in the presence of A9, the microwave oven in the patient nutrition area on 3 South, 4 South, and the Progressive Care Unit were observed soiled with debris and dried food material on the bottom, sides, and/or top of the microwave oven.</p> <p>3. Facility policy "Blood Glucose Monitoring with the Accucheck Inform System", last reviewed/revised 1-1-2013, provided on page 5, Maintenance, 3. Cleaning c. "When cleaning the AccuChek meter, do not allow the cleaning solution to come in contact with the meter connector or pool in the base".</p> <p>4. Facility policy "Infection Prevention Policy for Standard Precautions", last reviewed/revised 1-2013, provided on page 2, Environmental Control, A. "Clean blood body fluids as soon as possible...".</p> <p>5. Facility policy "Patient Food Services", last reviewed/revised 5-23-2012, provided on page 1, 5. "Hostess is responsible for daily cleaning and sanitation of the unit pantry, unless</p>		<p>and the accessory box of the Accucheck machine is cleaned according to Manufacturers recommendations. (See attached) A log will be kept to initial that the base and accessory box has been cleaned. 3. The current Accucheck meter, base and accessory box can be cleaned with the CaviWipes that are available. 4. Signage can be posted it is up to each area. July 1 st the new meter will be available. The education for the new meter includes cleaning the base and accessory box. There will also be a separate cleaning policy for the Accucheck Inform meter II. The change for the new meter will be in the cleaning product but the cleaning process can remain weekly. For the Microwave Ovens: Environmental Services Manager, will now include this activity with the CHS EVS team. The staff were educated to include this in the cleaning regime, and a log was created that microwaves will be cleaned 1x/week and will be checked 1x/week byt the EVS supervisor. The log must be signed, and will be checked during weekly rounding. This became effective 6/10/13.</p>		

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	<p>otherwise indicated".</p> <p>6. During interview with A4, on 5-21-13 at approximately 11:00 AM, A4 indicated :</p> <p>a. that the facility policy did not address the requirements/procedure for cleaning of the AccuChek docking station.</p> <p>b. no-one had contacted the manufacturer, Roche, for information regarding the recommended cleaning procedures for the docking station of the AccuChek units.</p> <p>c. that facility expectation is for nursing staff to clean the AccuChek docking stations regularly and as needed to prevent the contamination of a previously disinfected meter unit when placed in the docking station.</p> <p>d. dietary services are assigned to clean the patient pantry areas to include the microwave ovens.</p> <p>e. microwave ovens must be cleaned regularly and as needed to prevent the harboring of infectious microorganisms in the debris in the oven to reduce the risk of transmission of infectious microorganisms to patients in their food.</p>			
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S000754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and interview, the facility failed to implement its informed consent policy for 3 of 3 obstetrical medical records reviewed (N 25, N27, and N31) and 1 of 9 surgical services medical records reviewed (N24).</p> <p>Findings included:</p> <p>1. During review of medical records on 5-22-13, a. N24 was admitted on 3-11-13 for Right Total Hip Arthroplasty and was discharged on 3-14-13. The informed consent for N24's surgical procedure was electronically authenticated by the physician on 3-21-13. The medical record lacked documentation of a discussion between the physician and N24 of the benefits, risks, any alternative</p>	S000754	Physician education will be dispersed on the need to inform patients about the benefits, risks, and alternative options and possible complications to surgical procedures to be done prior to a procedure. In Surgery, memos will be posted in physician gathering areas and staff will be educated not to take the patient to a procedure until the following criteria has been completed. This was completed by Director of Surgical services. VPMA will be monoting this process through the review of audits reported monthly. In addition to the above, the concern was brought before the Medical Executive Committee on June 11 th , 2013. The VPMA discussed the importance of the informed consent, and discussion was had, and the decision was made to begin an audit of records to include 25 records per month, to insure that	06/11/2013

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	<p>treatment options, and possible complications to the N24 prior to the surgical procedure.</p> <p>b. N25 was admitted to the Family Room unit (Obstetrics) on 4-13-13 for Obstetrical delivery and sterilization and was discharged on 4-16-13. The informed consent for N25's surgical procedure was electronically authenticated by the physician on 5-9-13. The medical record lacked documentation of a discussion between the physician and N25 of the benefits, risks, any alternative treatment options, and possible complications to the N25 prior to the surgical procedure.</p> <p>c. N27 was admitted to the Family Room unit (Obstetrics) on 4-14-13 for Obstetrical delivery and sterilization and was discharged on 4-16-13. The informed consent for N27's surgical procedure was not authenticated as of 5-22-13. The medical record lacked documentation of a discussion between the physician and N27 of the benefits, risks, any alternative treatment options, and possible complications to the N27 prior to the surgical procedure.</p> <p>d. N31 was admitted to the Family Room unit (Obstetrics) on 4-15-13 for Obstetrical delivery and was discharged on 4-17-13. The informed consent for N31's surgical procedure was authenticated on 5-5-13. The medical</p>		<p>this is being completed in all areas that consent is used. All non-compliant issues will be brought before the Quality Assurance Leadership Committee for Physician follow up monthly. In addition to this a committee is being formed to discuss the implementation of the consent in the electronic medical record. This committee is being chaired by Director of Health Information and Site Leader for Quality Resources. Further education will occur through the use of the electronic bulletin boards.</p>		

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	<p>record lacked documentation of a discussion between the physician and N31 of the benefits, risks, any alternative treatment options, and possible complications to the N31 prior to the surgical procedure.</p> <p>2. Facility policy " Consent for Medical Treatment", last reviwed/revised 4-15-13, provided on page 2, B. General Rules of Consent, 1. "The physician is responsible for providing information and documenting the benefits, risks, any alternative treatment options and possible complications to the patient..."</p> <p>3. During interview with A12 on 5-22-13 at approximately 12:45 PM, A12 indicated:</p> <p>a. A12 confirmed the findings in the medical records.</p> <p>b. an obstetrical delivery is a surgical procedure subject to the facility's Informed Consent policy.</p> <p>c. confirmed that the above medical records did not document an emergency medical condition which would have obviated the requirement for a completed informed consent to include documentation of the discussion between physician and patient regarding the benefits, risks, alternative treatment</p>			

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	options, and complications in the medical record prior to the surgical procedures. d. the medical records were not completed as per facility policy.			

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S000788	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(9)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(9) Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be recorded.</p> <p>Based on document review and interview, the facility failed to assure a completed transfer form was in the medical record for 2 of 4 Emergency Department transfer medical records reviewed.</p> <p>Findings included:</p> <p>1. During review of medical records of patients transferred from the facility Emergency Department (ED) to another facility:</p> <p>a. N4, a 3 year old, presented to the ED on 4-25-13 at 11:15 PM for vomiting and was transferred to another facility on 4-26-13 at 7:35 AM. The transfer record lacked documentation of the risks and benefits of transfer by the physician and documentation that N4's ED medical record had been forwarded to the receiving facility.</p> <p>b. N5, a 92 year old, presented to the ED</p>	S000788	<p>The transfer documentation process will be re-educated in the ED with assistance from Community Care Connect ASAP team regarding the current transfer/PCS paper form and also the required documentation in the Epic system. ED Director will be responsible for ensuring this education is reviewed for content and implemented with the ED leadership team and education coordinator. We'll accomplish this education through upcoming ED Team day (mandatory education days) in June 2013. We will also provide weekly reminders through the month of July as we hardwire this process. Our ED nurse managers will begin a weekly audit process to review our transfer log and audit each case for completed and accurate transfer documentation. We'll continue these audits for a 3 month period (July, August, September) with providing</p>	06/24/2013			

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	<p>on 4-27-13 following a fall and was transferred to another facility. The medical record lacked any documentation of a completed scanned transfer record or of electronic transfer documentation for N5 per facility policy.</p> <p>2. Facility policy "EMTALA: Emergency Medical Screening, Stabilization, and Transfer", last reviewed/revised 5-18-12, provided on page 4, d, iii "A physician certifies that the medical benefits reasonably expected from the provision of medical treatment at another facility outweigh the risks to the individualfrom being transferred"; on page 5, e., iii. defines an appropriate transfer to require "the Hospital sends copies of all medical records related to the presenting EMC [Emergency Medical Condition] that are available at the time of the transfer to the receiving facility, and copies of any other records not available at the time of transfer to the receiving facility as soon as possible after the transfer"; on page 8 the checklist tool includes #1 the requirement of physician certification of risks/benefits, a completed transfer form, and the requirement to send copies of all medical records to the receiving facility.</p> <p>3. During interview with A12 on 5-22-13 at approximately 12:45 PM, A12</p>		<p>feedback/instruction back to ED nursing staff. We will evaluate after September 2013 to need to further require these weekly audits. ED Director will own leading the initiative for reviewing the needed changes for the optimal ED Transfer documentation process. The optimization process for our EMR and this particular process within our EMR is ongoing, our optimal process will include development of a 100% electronic transfer form/content, and exclude the paper process.</p>				

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	<p>indicated:</p> <p>a. A12 confirmed the findings in the medical records.</p> <p>b. the facility has recently, within the last 3 months, converted the transfer form from a scanned document to entry directly into the electronic medical record, but that the facility policy applies to documentation whether on paper form or directly entered electronically.</p> <p>c. the medical records above were not completed as per facility transfer policy.</p>			

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S000952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to follow an approved medical staff policy/procedure for one of seven blood transfusions reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> On 5/20/13 between 4:00 p.m. and 4:30 p.m. a review was conducted of a policy/procedure titled: "Blood Component Administration NPP#: I-14B1 EFFECTIVE: 7/17/12" which stated: "13. b. "By obtaining and recording the temperature, pulse and respirations (T-P-R) and blood pressure (B/P) before the transfusion and....." Review of transfusion record T#2 indicated the prior vitals were taken at the same time as the transfusion was started: i.e. at 20:47. In interview on 5/20/13 between 2:30 p.m. and 3:30 p.m., staff person #1 	S000952	<p>An education plan was formulated with a power point used for education purposes. All stake holders were consulted. This is the plan that was rolled out on June 18 th , 2013 to CHS: Blood Management Officer audits compliance with MACL's request for correction of yellow transfusion copy sheets after one month to allow time for processing in the electronic medical record. Ongoing processes will follow up report to MACL and unit manager. Audit results reported at Transfusion and Blood Management Committee, Nursing/Laboratory meeting and IV advanced Practice meeting by Blood Management Officer.</p> <p>Responsibility: Staff nurses to comply with the Blood Administration policy to document at required intervals. MACL to audit transfusion record for accuracy. Managers to assure accuracy/correction of transfusion</p>	06/18/2013			

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	acknowledged the before vitals were taken as the transfusion was started and were not taken as the policy/procedure in effect at the time of the transfusion specified.		sheet. Blood Management Officer audits compliance , provides education and feedback to managers/committees.	

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S001014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on observation, document review, and interview, the facility failed to implement its policy in relation to the use of multi-dose injectable medications in 1 of 11 units toured (Surgical Services).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During tour of the Surgical Services Department on 5-21-13 in Operating Room 2 anesthesia cart, a vial of Flumazenil 5mL was in the drawer; the vial's rubber stopper had been punctured and the vial lacked documentation of a "do not use beyond" date. 2. Facility policy "Use of Injectable Multiple and Single Dose Containers", last reviewed/revised 5-2012, provided on page 1, 3 "Injectable medications in multi-dose containers will be dated with the expiration date directly on the vial". 3. During interview with A4 on 			S001014	<p>Multi-use vials that have been punctured will be dated 28 days out from the point that they were first used. Vials that do not have a date will be considered expired and disposed of immediately. Anesthesia will be educated that it is necessary to date and time all multi-use vials. Upon daily rounding of the OR, management will dispose of vials that are improperly labeled with date and time. Staff will be educated to do the same at the next staff meeting on June 19th, 2013. The Medical Director from Anesthesia, will be notified to alert the anesthesia team of the proper process for multi-use vials. Rounding will be completed by Director of Surgical Services, and Team Leader of Surgical services.</p>		06/19/2013

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	<p>5-21-2013 at approximately 11:35 AM, A4 indicated:</p> <p>a. the date that medications intended for multiple doses were opened cannot be reliably determined absent the dating on the vial as required by facility policy.</p> <p>b. presence of opened multiple dose vials which have not been dated present a risk of outdated or contaminated drugs being used in patient care.</p>			

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S001024	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</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>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on observation and document review, the hospital failed to store outdated drugs in a separate area from general inventory in 1 instance.</p> <p>Findings:</p> <p>1. Review of hospital policy PPP#FLSTK002, entitled MEDICATION STORAGE AREA INSPECTIONS (AKA UNIT INSPECTIONS), reviewed 5/12, indicated all drugs which are dated to expire prior to completion if the next full inspection are to be removed.</p> <p>2. On 5-20-13 at 12:20 pm in the presence of employee #A3, it was observed in the Pharmacy in the in-use stock storage area, there were 30 vials,</p>	S001024	<p>Plan of Correction S1024-Pharmaceutical Services for May 2013 Visit 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · Standardize our unit inspection process to be the same as the rest of the Network Acute Care Pharmacies. · Bulk storage areas where expired meds were found was not listed as an inspection area in pharmacy and was not assigned to anyone.2. How are you going to prevent the deficiency from recurring in the future? · Review the FLSTK002 Medication Storage Area Inspections policy with staff · Each area of the pharmacy will be assigned to a specific employee to inspect on a monthly basis as per policy with</p>	06/14/2013	

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	each containing 4 mg Piperacillin and .5 mg Tazobacter for injection, and each vial had an expiration date of 5-1-2013.		documentation. 3. Who is going to be responsible for numbers 1 and 2 above; ie, Dierctor, supervisor, etc? · Pharmacy Director-4. By what date are you going to have the deficiency corrected? · Expired product was moved to designated outdate section in pharmacy on date of audit. · May 29 th and 30 th , 2013 – Pharmacy staff meetings staff were informed of deficiency and reminded about location of short and outdated products to be moved to segregated area. · Revised unit inspection process was developed and shared in staff meetings on June 13 th and 14 th , 2013.		

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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 2 instances.</p> <p>Findings:</p> <p>1. On 5-20-13 at 2:20 pm in the presence of employee #A3, it was observed in the maintenance shop hazard closet there was a large compressed gas cylinder tank and a small gas cylinder tank on the floor, chained to each other. The chain was loose and positioned low on the large tank, so that if the large tank fell over it would knock over the small tank.</p> <p>2. On 5-22-13 at at 9:30 am in the presence of employee #A3, it was observed in the construction area on the fifth floor, there was an acetylene tank on the floor unsecured by chain or holder.</p>	S001118	Lg. and Sm. Cylinder tanks chained together---Director of Facilities · Maintenance shop cylinder chains were reconfigured at the time of the tour. No follow-up required.Small cylinders in-use by Mechanical contractors were all chained the following day. They continue to be secured.This will be monitored by Director of Facilities.	05/22/2013	

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	4. If any of the above extinguishers and tanks were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.			

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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 backflow prevention devices 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 5-20-13 at 2:15 pm in the presence of employee #A3, it was observed in the maintenance shop there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S001150	<p>Flexible hose without backflow device--Director of Facilities. Temporary Garden hose was removed from utility sink in maintenance at the time of the tour. No need to install backflow device. This will be monitored during monthly rounding.</p>	05/22/2013			

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S001168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, it could not be determined if the hospital properly completed monthly checks for 1 of 1 defibrillators.</p> <p>Findings:</p> <p>1. Review of a document entitled Zoll AED PLUS 2012 Department South Sleep Center, indicated <u>Once every month</u>, the "MONTHLY CHECK MUST BE COMPLETED." Document completion of this check by <u>circling your initials</u>.</p> <p>2. Review of the above document indicated for each day of entry for the entire year of 2012, there were no times when the person's initials were circled. Thus, it could not be determined if the individual was completing the monthly check.</p>	S001168	<p>The deficiency found was the AED located at Community Health Network's Sleep/Wake Disorder Center, located at 333 E. County Line Rd. Suite D. The AED did not have proper monthly maintenance checks performed. This deficiency was corrected by re-educating staff members on how to perform monthly maintenance checks on the AED and making it mandatory to be completed on the 15 th of each month. The deficiency will be prevented from recurring in the future by following up and visually checking the checklist to make sure it has been signed off on for the monthly check. Sleep Lab Manager, will be responsible for following up to make sure the monthly check was completed. The deficiency will be corrected beginning 6/15/13 and each month thereafter on the 15 th of each month.</p>	06/15/2013			

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S001197	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the hospital failed to have written documentation of a regular, within the last year, state or local fire inspection.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of documents indicated the last time the facility had a local or state fire inspection was in 2011. 2. In interview, on 5-21-13 at 4:05 pm, employee #A6, after being requested to provide documentation of a more recent inspection or documentation of a request for a local or state fire inspection, indicated there was no documentation of a more recent inspection and no documentation of a request for same within the past year. No other documentation was provided prior to exit. 	S001197	<p>The rule sighted states that the facility should have <u>regular</u> inspections by the Fire Department (the regulation does not specify a frequency). As a facility operator we have no control over the timing or frequency of these inspections. While we did not receive a formal visit in 2012, we did host several building tours by the Perry Township Fire Department - Engine 62 in Dec. 2012, and offered documentation of Fire Department site visits in 2009, 2010, & 2011 all of which were ignored by the surveyor as evidence of compliance. The Surveyor stated that we should have formally documented our request for inspection in 2012 even if the Marshall did not visit – which is not required by regulation. We have once again reached out to the State Fire Marshalls office (as recently as 6/12/2013) and await for their response to our inquiry. -- -Director of Facilities</p>	06/12/2013			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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