

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2013
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NAME OF PROVIDER OR SUPPLIER ESKENAZI HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 720 ESKENAZI AVENUE INDIANAPOLIS, IN 46254
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005023</p> <p>Survey Date: 03-04/08-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 03/20/13</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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S000312	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</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>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on document review and interview, the facility failed to perform annual performance evaluation for 2 of 2 contract dialysis nursing staff (Staff #1 & 2).</p> <p>Findings include:</p> <p>1. Review of staff #1 & 2's personnel file indicated each was hired as contract dialysis nurses and each had been with the facility greater than 12 months. Each file lacked documentation of having annual evaluations performed by the facility.</p> <p>2. On 03-08-13 at 1535 hours, staff #40 confirmed that the facility did not perform annual evaluations for staff #1</p>	S000312	<p>Evaluation process for DaVita (contracted dialysis) staff reviewed. Process change implemented that will allow for Wishard's Director of Critical Care, who also has responsibilities for the Renal Service Line, to be given the opportunity for input into DaVita staff evaluations. The plan was developed via collaboration with DaVita's leadership team, nursing director of Critical Care, and quality/risk management. Wishard will receive a listing of DaVita staff that work at Wishard with their corresponding evaluation due dates. This listing will serve as the trigger to alert the Critical Care Nursing Director of the opportunity to offer input. This same list will also go to the Wishard Renal Service Chief.</p>	05/31/2013

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	& #2.		This will allow the physician to give input as well. Notice will be placed within each staff member's evaluation that the opportunity was given for input and/or the specific feedback from Wishard team members. DaVita evaluations for 2012 have been completed with the exception of one PRN staff member. The evaluations completed after the ISDH visit have been reviewed with the identified Wishard staff and the notice of input/feedback has been placed into the evaluations via the process described above. The Director of Critical Care is responsible for the monitoring of compliance with this action plan. The monitoring schedule will be random and will be dependent on receipt of the staff listing from DaVita. There is one remaining staff member to be evaluated in 2013 for the 2012 practice (this has now been completed).		

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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 5 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of hospital POLICY NO: 700-124, entitled Cardiopulmonary Resuscitation (CPR) Competence for Medical and Allied Health Staff and the Code Team, revised 11/2011, indicated Cardiopulmonary resuscitation (CPR) competence is required for</p>	S000318	Policy 700-124, Cardiopulmonary Resuscitation (CPR) Competence for Medical and Allied Health Staff and the Code Team has been reviewed. The current policy states "CPR competence is required for the following physicians, dentists, and allied health practitioners: physicians responding to codes as part of the Code Team, those medical staff members who must comply with Medical Care Administration Policy 700-144, Moderate and Deep Sedation Privileges, and allied health practitioners, with the exclusion of psychologists. The proposed amendment to the current policy states "direct care givers in emergent situations are universally privileged to operate	10/22/2013			

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	<p>[various groups of credentialed medical staff] and all residents, as part of the Code Team, hold and maintain current ACLS or PALS certification as a residency requirement.</p> <p>2. Because only certain groups of credentialed medical staff members were specified by hospital policy as to the requirement of CPR competency, it is concluded the remaining members were competent in accordance with current standards of practice.</p> <p>3. Review of 7 medical staff credential files indicated files MD#1, MD#2, MD#5, MD#6, and MD#7 did not have any documentation of CPR competency in accordance with current standards of practice.</p> <p>4. In interview, on 03-07-13 at 3:30 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p>		<p>as fully privileged with basic life support skills and the medical staff recognizes them to do so without any certification. They are trained to call the Code 99 Team in the inpatient setting and to call 911 in the outpatient setting." This policy revision was presented to the Critical Care Committee (a physician committee) in April 2013. The policy was distributed to the medical staff for a comment period. The policy and the incorporated feedback will be presented to the Clinical Services Oversight Committee in September 2013. The policy will be presented to the Board for final approval in October 2013. The Clinical Nurse Specialist for Critical Care has been identified as being responsible for policy changes and for facilitating the policy through the internal policy approval process.</p>		

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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.</p> <p>Based on observation and interview the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients in 3 incidents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 03-04-13 at 1105 hours during the tour of the Emergency Department the following was observed in the Respiratory Therapist storage room: personal bags on shelf with patient care supplies and 1 apple lying on a window sill next to supplies. 2. On 03-04-13 at 1105 hours, staff #51 confirmed that staff have an area to store personal items. 3. On 03-05-13 at 1110 hours, staff #50 confirmed that the Central Processing personnel use 70% alcohol to disinfect the instrument wrap tables. 4. On 03-08-13 at 1605 hours, staff #40 confirmed the facility has not approved 	S000554	<p>#1 & 2: The finding related to personal items being left in supply rooms was presented at the March 12th, 2013 Leadership Forum. Members of leadership were requested to educate their respective staff members related to the importance of not placing personal items in supply areas. Further, the information was communicated to members of Quality Council on April 2, 2013. The Environmental Safety Officer will make this an item for inspection during Patient Safety Rounds to facilitate monitoring for compliance. The Environmental Safety Officer will monitor for compliance during Patient Safety Rounds. Rounds occur in patient care areas on a weekly basis. Areas with issues of noncompliance will be followed up by the Environmental Safety Officer with the specific leadership of the area. Each Director will be responsible for their own area. #3 & 4: The finding related to the nonapproved utilization of 70% alcohol by the Central Processing staff will be taken to Infection Prevention and Control</p>	04/30/2013			

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	<p>70% alcohol as a disinfectant.</p> <p>5. On 03-05-13 at 1145 hours during the tour of the Cardiac Cath area, the following was observed: in supply room 3219 - 25 boxes of interventional radiology (IR) catheters lying directly on the floor. in a sterile supply room was a personal sweater hanging near sterile supplies.</p> <p>6. On 03-05-13 at 1145 hours, staff #52 confirmed that the IR catheter boxes should not be on the floor.</p>		<p>Committee on April 10, 2013 for discussion and possible approval. 70% Alcohol was pulled from this area for disinfection purposes during the time of survey pending the approval of it's use. The Manager of Infection Prevention and Control is accountable for cleaning/disinfecting agents to be taken to IPC Committee for approval prior to use. The Manager of Infection Prevention and Control conducts weekly rounds in the Central Processing area and will monitor the agents being utilized during these rounds. #5& 6: The finding related to IR supplies lying directly on the floor was communicated to IR leadership during the time of survey. The Chief Tech for IR will be accountable for inspecting the supply areas each day and by keeping a "check off log" to make certain that rooms are stocked properly and remain in compliant condition as items are stocked and utilized. The Chief Tech will bring subsequent issues with noncompliance to the attention of his area leadership. The Director of IR is ultimately responsible for compliance with storage of supplies and equipment.</p>		

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview the facility failed to ensure that no creation be created or maintained which may result in a hazard to patients, public, or employees for 1 sterilizer access room and 1pulmonary biomed shop.</p> <p>Findings include:</p> <p>1. During the facility tour of the Central Processing area on 03-05-13 at 1115 hours the following was observed in the autoclave access room: the room was very warm with paper trash, scrubs, disposable cover suits and surgical towels on the floor.</p> <p>2. On 03-05-13 at 1115 hours, staff #50 confirmed that the paper trash, scrubs, disposable cover suits and surgical towels should not have been on the floor in the autoclave access room.</p>	S001118	The autoclave access room was cleaned up at the time of survey. Team leads in the area obtained keys so that this area could be monitored during their normal weekly rounds to ensure cleanliness. Further, the room has been added to the Infection Prevention and Control monthly rounds in the Central Processing area. The Assistant Director of Perioperative Services has been identified as accountable for the monitoring of compliance. The citation related to the oxygen tank that was found unsecured in the Pulmonary BioMed shop will be addressed by having a member of the Pulmonary Lab Biomedical staff monitor the oxygen tanks within the department daily. The checks will be logged and monitored for 6 months. The Director of Bio Med is accountable for achieving and maintaining compliance. Compliance with the	03/11/2013	

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S001168	<p>3. On 03-05-13 at 10:05 am in the presence of employees #A3 and #A4, it was observed in the Pulmonary Biomed Shop, there was 1 small oxygen tank on the floor unsecured by chain or holder.</p> <p>4. If the above tank was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <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, the hospital failed to follow its policy to properly keep a daily discharge log for 1 of 1</p>	S001168	<p>checklist completion will be facilitated by the generation of a daily electronic work order that will serve as the reminder to the staff to verify compliance with the securing of oxygen cylinders. The monthly audit for compliance will be presented at the Environment of Care Committee.</p> <p>The Radiology Services Emergency Equipment Checklist was noted during survey to be noncompliant with checking the</p>	04/30/2013	

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	<p>defibrillators.</p> <p>Findings:</p> <p>1. Review of hospital POLICY NO.: 950-126, entitled Cardiopulmonary Resuscitation/Code 99 Response, revised 01/2012, indicated emergency equipment ... will be checked as noted: Checked every 24 hours the area is in operation</p> <p>2. Review of a document entitled Radiology Services Emergency Equipment Checklist, Inpt Area, for the months of January, February and March, 2012, indicated out of 90 days, there were no entries for 14 days (15%).</p>		<p>defibrillator 15% of the time during the first quarter of 2012. Radiology staff members were educated regarding Policy 700-040, Equipment Checks by their department manager and that failure to be compliant with the checking of the emergency equipment will result in progressive disciplinary action. This manager is responsible for monitoring staff compliance with the equipment check policy. It is important to note that this equipment is located in an outpatient department and will be checked every day that the department is open and seeing patients. The compliance of the completion of the emergency equipment checks will be reported by the Radiology Manager at the Environment of Care Committee.</p>		

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S001186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</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>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy for 18 of 18 offsite facilities.</p> <p>Findings:</p> <p>1. Review of hospital POLICY NO; 950-156, entitled Fire Drills, approved 5/3/2011, indicated fire drills shall be scheduled in accordance with guidelines established by The Joint Commission Standard EC.02.03.03.</p>	S001186	<p>Wishard Health Services Policy 950-156, Fire Drills, states "Fire drills shall be scheduled in accordance with guidelines established by The Joint Commission (TJC) Standard EC.02..03.03". TJC Standard EC.02.03.03 EP1 reads as follows: "The hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the Life Safety Code. The hospital conducts quarterly fire drills in each building defined as an ambulatory health care</p>	04/24/2013			

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	<p>2. In interview, on 3-4-13 at 1:40 pm, employee #A3 indicated the The Joint Commission Standard required the hospital to conduct fire drills quarterly, per shift.</p> <p>3. Review of the hospital's State of Indiana license indicated there were 18 offsite hospitals listed as part of the hospital license. Thus, all the offsites were subject to all of the hospital's approved policies.</p> <p>4. In interview, on 3-4-13 at 1:40 pm, employee #A3 indicated the hospital conducted fire drill at all 18 offsites, once per year, per shift. Thus, the facility failed to conduct fire drills in accordance with facility policy (once per quarter per shift) for 18 of 18 offsite facilities.</p>		<p>occupancy by the Life Safety Code". TJC Standard EC.02.03.03 reads as follows "The hospital conducts fire drills every 12 months from the date of the last drill in all free-standing buildings classified as business occupancies and in which patients are seen and treated". Life Safety Code 101.3.3.134.7 defines Health occupancy as "An occupancy used for the purposes of medical or other treatment or care of four or more persons where such occupants are mostly incapable of self-preservation due to age, physical or mental disability, or because of security measures not under the occupants control". Life Safety Code 101.3.3.134 defines Ambulatory Health Care occupancy as "A building or portion thereof used to provide services or treatment simultaneously to four or more patients that (1) provides, on an outpatient basis, treatment for patients that renders the patients incapable of taking action for self-preservations under emergency conditions without the assistance of others; or (2) provides, on an outpatient basis, anesthesia that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others". Life Safety Code 101.3.3134.3 defines Business occupancy as "An occupancy used for account and</p>		

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			record keeping or the transaction of business other than mercantile". As clarification, LSC 101A.3.3.134.3 reads in part as follows: "Business occupancies include the following: (5) Dentists' offices (6) Doctors' offices (8) Outpatient clinics, ambulatory" Based on this these sources, Wishard Health Services contends that were are in compliance with our organizational policy in that we do conduct annual fire drills at our off-site locations as business occupancies per Life Safety Code defintion. Wishard maintains documentation for fire drills at each offsite location and remaina in compliance with our organizational policy. Wishard's Environmental Safety Officer reached out to 18 offsite locations and educated the respective leaders on the necessity to begin conducting fire drills at each location once per quarter/per shift. The Environmental Safety Officer is ultimately responsible for oversight of the drill process, for maintaining the documentation of each drill and for follow up of concerns brought forward by each drill. The Environmental Safety Officer has the ultimate responsibility for tracking and follow up with non compliant sites. All offsite locations are on track to be compliant for 3rd quarter 2013.	

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S002136	<p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8 (c)(7)</p> <p>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:</p> <p>(7) An operative report describing techniques, findings, and tissue removed or altered shall be written or dictated immediately following surgery and authenticated by the surgeon. Based on document review and interview the facility failed to ensure that operative reports describing techniques, findings, and tissue removed or altered be written or dictated immediately following surgery for 3 of 7 surgical medical records (MR) reviewed (Patient #22, 25 & 26).</p> <p>Findings include:</p> <p>1. Review of the following MRs indicated the following: patient #22 had surgery on 01-31-13 and the operative report was dictated on 02-04-13. patient #25 had surgery on 02-01-13 and the operative report was dictated on 02-03-13. patient #26 had surgery on 01-30-13 and the operative report was dictated on</p>	S002136	<p>Medical Staff Administration Policy 700-57, Content of the Medical Record, specifies and defines requirements of medical staff documentation. This policy identifies that a post operative progress note must be present in the medical record immediately following the surgery to provide pertinent information. This note should include at least the following information: post operative diagnosis, name of primary surgeon and any assistants, technical procedures used, description of findings, specimens removed (if any) and estimated blood loss (if any). A review of the MRs that were assessed by the surveyor during the time of survey occurred the week following the actual Licensure Survey. The medical records for Patient #22, Patient # 25, and Patient #26 were reviewed specifically for the</p>	04/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013
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	02-10-13. 2. On 03-07-13 at 1500 hours, staff #55 confirmed the dates the Operative Reports were dictated.		timeliness of the Operative Note. Findings are as follows: Patient #22 had surgery on January 31, 2013. The immediate Operative Note was placed in the Gopher system at 0905 on January 31, 2013. The Operative Report was dictated on February 4, 2013. Patient #25 had surgery on February 1, 2013. The immediate Operative Note was placed in the Gopher system at 1629 on February 1, 2013. The Operative Report was dictated on February 3, 2013. Patient #26 had surgery on January 30, 2013. The immediate Operative Note was placed in the Gopher system at 2020 on January 30, 2013. The Operative Report was dictated on February 10, 2013. Wishard maintains that all pertinent information as defined by Policy 700-57 was available in each patient's medical record immediately following each of the above surgical procedures thereby facilitating safe care of the patient by post operative and inpatient care staff. The staff members reviewing the records with the surveyor were looking for the dictated Operative Report and failed to search for the immediate post-operative note. The Service Chief for Perioperative Services has re-educated the surgical services physicians on the importance of having an immediate operative report available in the electronic record for enhanced continuity of care		

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			and patient safety.	