

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005068</p> <p>Survey Date: 1-23/27-12</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 02/02/12</p>	S0000		

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

TITLE

(X6) DATE

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

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S0270	<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 for calendar year 2011, quality monitoring reports for 7 services directly-provided by the hospital, 6 services provided by a contractor, and reportable events, all as part of the hospital's comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2011 indicated they did not include reports for the directly-provided services of cardio-rehab, central sterile, mammography (on site), neonatal nursery, 3 occupational health offsites, the contracted services of biohazardous</p>	S0270	<p>Actions taken to correct deficiency: The Quality Resource Site Leader met with each Director responsible for the Quality Indicator data reported to the governing board for the cited services. Each department is now being represented on the 2012 Quality Indicator Report to the Board. The surveyor documented that there were no Reportables as apart of the Quality Indicator Report. At the time of the survey, there was none known. Monitoring to prevent recurrence: The Director provides quality data to the Quality Resource Site Leader for entering into the Quality Indicator Board Report quarterly and the Report is shared at the Quality of Care meeting of the Board. Responsibility: Directors of the cited departments and the Site Leader of Quality</p>	02/24/2012	

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	<p>waste, blood bank, dietary, laundry, mobile PET Scan and tissue transplant, and reportable events.</p> <p>2. On 1-26-12 at 3:15 pm, employee #A14 was requested to provide the above documentation and none was provided prior to exit.</p>		Resources.Date of Correction:2/24/2012	

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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</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:  (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on review of documents and interview, the facility lacked policies and procedures reviewed at least triennially for mammography service.</p> <p>Findings:</p> <p>1. On 1-26-12 at 9:30 am in the presence of employee #A15, it was observed the mammography area was within the footprint of the hospital building, approximately 100 feet from the hospital's main entrance.</p> <p>2. On 1-26-12 at 9:30 am in the presence of employee #A15, it was observed in the mammography area there was a sign in the area's reception room indicating Community Hospital East's Patient Rights.</p>	S0322	<p><b>Actions Taken to correct deficiency: All policies and procedures for the mammography center will be reviewed at least triennially by the Medical Director for Mammography Services, the Manager of Mammography Services, the Director of Medical Imaging, and the Radiation Safety Officer. Evidence of the review will be documented and a copy of the policies and procedures will be kept in the Mammography Department as well as on the Imaging g-drive so that it is always available to Hospital management. Monitoring to prevent recurrence: This policy manual has been added to the review cycle for Imaging policies and procedures. Responsibility: The Director of Medical Imaging and the</b></p>	02/25/2012	

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	<p>3. On 1-26-12 at 10:00 am, employee #A16, a staff employee in the mammography area, was requested to provide documentation of the department's policies and procedures and when they were last reviewed and updated by the hospital. Employee #A16, upon interview, indicated he/she could not provide the documentation and no other documentation was provided prior to exit.</p> <p>4. On 1-26-12 at 2:00 pm, upon interview, employee #A14, indicated after discussion with the hospital's Chief Financial Officer, the mammography service was using the hospital's Medicare Provider Number to identify itself.</p> <p>5. Review of the lease for the space used by the mammography area indicated the space was leased to an entity that was not part of the hospital's ownership.</p> <p>6. Review of a document entitled OFF PREMISES LIST FOR FACILITY, as part of the hospital's license, indicated the mammography area was not on the list.</p>		<p><b>Manager of Mammography Services Date of Correction: Policies and Procedures were completed and sent to Director of Medical Imaging, 2/25/2012. Review will be completed and documented, and Policies and Procedures included with Imaging policies by 3/26/2012.</b></p>		

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S0362	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D) (E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review, the hospital failed to comply with their contract by not notifying their organ procurement organization of 2 of 442 deaths for the year 2011.</p>	S0362	<b>Actions Taken to correct deficiency: Community Health Network, in conjunction with the Network Donor Council, will review processes related to organ donation referrals and</b>	02/24/2012			

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	<p>Findings:</p> <p>1. Review of the contract between the hospital and the Indiana Organ Procurement Organization (IOPO), indicated [the] hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the Hospital.</p> <p>2. Review of a report entitled Community Hospital - East Donation 2011 Statistics and Benchmarks, indicated that for the period January 1, 2011 through December 31, 2011, there were 442 hospital deaths and 440 were reported to IOPO.</p>		<p><b>define continued opportunities for improvement. Action items to begin immediately include,</b></p> <p><b>1) Focused education on units</b></p> <p><b>2) Poster presentations for nursing areas</b></p> <p><b>3) House supervisor will continue to give card to RN when patient dies that reminds staff to call the Indiana Donor Alliance (IDA) and includes IDA phone number</b></p> <p><b>4) Continue to send quarterly newsletter to all clinical users reminding staff when to call the IDA</b></p> <p><b>5) Continue practice of having one on one conversation with the RN who failed to call the IDA when the patient died</b></p> <p><b>6) continue new employee orientation to IOPO process. <u>Monitoring to prevent recurrence:</u> Network Donor Council will continue to review the total death report monthly during the Donor Council meeting and ensure that all appropriate units are included. Continue with current tracking tool to help identify trends. Review any missed calls and potential issues at the monthly donor council meetings. The donation dashboard will be submitted quarterly to CHE Quality Indicators Board Report for review.</b></p> <p><b><u>Responsibility:</u> Network Donor Council which includes representatives from multiple departments such as Nurse</b></p>		

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			<p><b>Managers, Respiratory Therapy, Billing, Chaplaincy, Education, HIM and Senior Leaders. <u>Date of Correction:</u></b>            March 21, 2012 All Community East Nurse managers will receive a packet provided by IOPO to continue educating staff members on when to call the IDA. The packet includes reminder stickers that have the phone number for the IDA, Posters for break rooms or nursing units and a letter discussing donation/death process. Each manager will be required to present information at scheduled staff meetings.</p> <p>Additional on-site in-services will be provided by IOPO during 2012 to increase awareness of referral triggers and donation/death process. We will continue to follow through with current process that include reminder to call the IDA cards to the RN taking care of the patient that has died, quarterly newsletters to all clinical users as a reminder to staff to always call the IDA, One on one follow up with any missed referral calls, and monthly review of dashboards at Network Donor Council. We will also work closely with the Network IOPO representative to deep dive educational opportunities. In January 2012, Community East had 41 deaths. 100% of deaths were called to the IDA.</p>		

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S0406	<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 7 services 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 services of cardio-rehab, central sterile, mammography (on site), neonatal nursery, 3 occupational health offsites and the contracted services of biohazardous waste, blood bank, dietary, laundry, mobile PET Scan and tissue transplant.</p>	S0406	<p>Actions taken to correct deficiency:The Quality Resource Site Leader met with each Director responsible for the Quality Indicator data reported to the governing board for the cited services. Each department is now being represented on the 2012 Quality Indicator Report to the Board. Monitoring to prevent recurrence:The Director has provided indicator data to the Quality Resource Site Leader for entering into the Quality Indicator Board Report quarterly and the Report is shared at the Quality of Care meeting of the Board.Responsibility:Directors of the cited departments and the Site Leader of Quality Resources.Date of Correction:2/24/2012</p>	02/24/2012			

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	2. On 1-26-12 at 3:15 pm, employee #A14 was requested to provide the above documentation and none was provided prior to exit.			

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S0420	<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>(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: (AA) that occur in the course of surgery; or (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: (AA) Objects intentionally implanted as part of a planned intervention.</p>			

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	<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> <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>			

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	<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; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. 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 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>			

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	<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 patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p>			

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	<p>(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.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's QAPI program indicated it did not include reportable events.</li> <li>2. On 1-26-12 at 3:15 pm, upon interview, employee #A14 indicated there were no reports of reportable events as part of the facility's QAPI and no documentation was provided prior to exit.</li> </ol>	S0420	There were no Reportable events reported because there were none known for 2011 at this time. Reportable events are reported and discussed by Quality Resource leadership at Quality of Care Committee of the Board when facilities have events of this nature occur.	01/27/2012	

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S0610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on chart review, observation during tour, and staff interview, the facility failed to have a program of food preparation and storage that includes monitoring of refrigerator temperatures per established policies/procedures and in compliance with the Indiana Food Code 410 IAC 7-24.</p> <p>Findings included:</p>	S0610	<p><b>Actions Taken to correct deficiency: 1.a- We have made the surveyor recommended changes to our temperature forms to include the time at which the temperature was taken as well as increased the frequency from weekly observation with corrective action to daily observation by leadership with a signature to document the observation as</b></p>	01/27/2012			

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	<p>1. On 1/23/12 between 10:00 a.m. and 2:00 p.m., tour of the main kitchen revealed 2 charts:</p> <p>a. One chart was "CRITICAL CONTROL POINT-COOLING" which stated: "Hot foods not used for immediate service must be cooled from 140 degrees to 70 degrees F within 2 hours and from 70 degrees F to below 41 degrees F within 4 hours for a total cooling time of 6 hours." This chart had 5 days where the recorded cooling times for foods were not complete. There was no corrective action to indicate what happened to those foods, discarded or used, risking patient health. From 1-5-12 to 1-19-12 there had been no review of this documentation. 410 IAC 7-24-189 of the Indiana Food Code states: " Within 2 hours from 135 degrees Fahrenheit to 70 degrees Fahrenheit. Within 4 hours from 70 degrees Fahrenheit to 41 degrees Fahrenheit. The entire cooling process must be completed within 6 continuous hours."</p> <p>b. The second chart was labeled "Daily Thermometer Calibration Log" and stated: "All individual thermometers must be checked on a daily basis." Between 1-1-12 and 1-23-12 (the day of survey) there were 7 days which had no thermometers checked, some days had 1 checked, some had 2 checked and some had 3 checked. Staff person # cp1 indicated there were 8 thermometers</p>		<p><b>well as documented corrective action for critical control cooling points not meeting the standard. 1.b- For the daily calibration log we have modified the log to record each therm. temperature instead of just a checkmark showing that it was calibrated, as well as provided a daily required signature by leadership to show documented observation of completion of the therm calibration requirements. Monitoring to prevent recurrence:1.a- Documented observations have been added to the daily routine of the supervisors as well as a signature requirement has been added to the critical control point log to document that observations and corrective actions have been completed. 1.b- Documented observations have been added to the daily routine of the supervisors as well as a signature requirement has been added to the daily thermometer calibration log to document that observations and corrective actions have been completed Responsibility: 1.a and 1.b- Responsibility of the state regulatory compliance for the S610 Citation will be that of the Dietary Department Leadership Team and</b></p>				

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	<p>available in the kitchen. 410 IAC 7-24-254 states: "Food temperature measuring devices that are scaled in Fahrenheit shall be accurate to plus or minus 2 degrees Fahrenheit in the intended range of use." The chart did not indicate what the temperature measuring devices actually read.</p> <p>2. During the tour of the facility on 1-23-12 between 10:00 a.m. and 2:00 p.m., a sandwich vending machine was observed in the gift shop. When the surveyor asked if the temperature of the machine was monitored and if there was a lock on the machine to prevent sale of items if the temperature became out of range, staff person #cp1 indicated this was unknown. 410 IAC 7-24-264 states: " A machine vending potentially hazardous food shall have an automatic control that prevents the machine from vending food if there is a power failure, mechanical failure, or other condition that results in an internal machine temperature that cannot maintain food temperatures....."</p> <p>3. In interviews on 1-23-12 between 10:00 a.m. and 2:00 p.m., staff person #cp1 indicated the charts had not been maintained and reviewed as needed, the and the presence of the vending machine was unknown until day of survey.</p>		<p><b>supervisor team. Executive responsibility will be handled by Director of Dietary. Date of Correction: 1.a and 1.b proof of corrective action was provided to the SBOH on 1-27-2012 2.</b></p> <p>With regard to the sandwich vending machine in the gift shop, we do not consider this to be by definition a vending machine. According to our vendor and an inspector we contacted at the Indiana State Board of Health, this machine should be classified as a "Customer Self-Service Machine" and is not subject to the same requirements that traditional vending machines are. It does not accept money for the product, customers open the door and remove the items they wish to purchase, it does have a thermometer for monitoring temperature, the product is rotated weekly and each piece has an expiration date on it. The vendor (Landshire) has indicated to us that they have hundreds of these machines across the Midwest and none of them use a temperature monitoring device other than the conventional thermometer.</p>		

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S0732	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based on document review and interview, the facility failed to ensure that the medical record (MR) contain sufficient information to document accurately the course of treatment and justify the treatment for 3 of 25 MRs reviewed (Patient #2, 6 &amp; 7).</p> <p>Findings include:</p> <p>1. On 01-24-12 at 1110 hours during the facility tour of the Post Anesthesia Care Unit (PACU) patient #2's MR was reviewed. The Post Anesthesia Evaluation was documented as being completed on 01-24-12 at 1200 hours and the Anesthesia End time was 01-24-12 at 1333 hours.</p> <p>2. On 01-24-12 at 1110 hours staff #44 confirmed that the Post Anesthesia Evaluation was documented as being completed on 01-24-12 at 1200 hours and the Anesthesia End time was 01-24-12 at</p>	S0732	<p><b>Re: 1. and 2 related to Post-Anesthesia Care Unit</b> <b>Actions taken to correct deficiency:</b> Corrected 1-24-12 immediately after inaccuracy of time frames brought to the attention of the Medical Director of Surgery, Dr. Michael Guzman and made aware. He in turn discussed with anesthesiologist involved, who corrected the time frame documentation inaccuracies. <b>Monitoring to prevent recurrence:</b> 1. Education was provided 1-25-12 to all anesthesia staff by Medical Director of Surgery, Dr. Michael Guzman of accurate documentation of time frames. 2. Forty (40) charts will be audited for 3 months for accuracy and completeness of documentation. The results will be reported to the Medical Director of Surgery, Dr. Michael Guzman, and Executive Director, Lori Walton, RN. Start date 3-5-12 through 6-29-12. 3. See attachment for auditing. <b>Responsibility:</b> Medical Director of Surgery, Dr. Michael</p>	02/24/2012

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	<p>1333 hours.</p> <p>3. Review of patient #6's MR indicated that the patient was placed in a restraint on 10-03-11 at 0900 hours. Review of the Physician's Orders dated 10-03-11 at 0850 hours indicated the following; "Restrain for up to 4 hours." It could not be determined what type of restrain the Physician ordered.</p> <p>4. Review of patient #7's MR indicated that the patient was placed in a restraint on 10-19-11 at 0800 hours. Review of the Physician's Orders dated 10-19-11 at 0820 hours indicated the following; "Restrain for up to 2 hours." It could not be determined what type of restrain the Physician ordered.</p>		<p>Guzman, and Executive Director of Surgical Services, Lori Walton, RN. <b>Date of correction:</b> Immediately <b>1-24-12</b><b>Re: 3. and 4 related to type of restraint not indicated on physician order.Actions Taken to correct deficiency:</b> <b>(1) Inpatient Behavioral Care Director and Clinical Nurse Managers met with the Quality/Risk Site Leader to discuss the deficiency and required changes 2-23-12. (2) The Restraint/Seclusion preprinted order forms for behavioral restraint (youth and adult) were revised to include the type of restraint ordered: seclusion, 4-way restraint, 4 way restraint with body blanket, hold, or transport. (3) The draft version of the revised order forms were distributed to all inpatient staff with directors to begin use on 2-24-12. (4) A request for final revision of the forms was sent to HIM on 2-1-12. Monitoring to prevent recurrence:100% restraint documentation is reviewed in the daily chart audits by inpatient staff beginning 2-24-12 Responsibility: Behavioral Health Services Inpatient Director</b> Date of Correction:2/24/2012</p>		

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S0754	<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 follow its policy/procedure for Consent For Medical Treatment for 1 offsite.</p> <p>Findings include:</p> <p>1. Review of policy/procedure CLN-2026, Consent For Medical Treatment, indicated the following: "All patients must sign (or have signed on their behalf) the general "Patient Consent Agreement" at the time of admission as an inpatient or outpatient." This policy/procedure was last reviewed/revised on 04-12-10.</p> <p>2. On 01-24-12 at 1400 hours staff #50 &amp; 51 confirmed that patients at the Noblesville Medcheck offsite do not sign a consent for treatment.</p>	S0754	<p>Actions taken to correct deficiency: Consent For Medical Treatment process was corrected on 1/25/2012 with the Consent for Treatment Form added to the registration packet completed for each patient. Monitoring to prevent recurrence: When new billing systems are introduced in the future, leadership will ensure a Consent for Treatment is included. Responsibility: Nursing Director and Nursing Managers of the Med Checks. Date of Correction: 1/25/2012</p>	01/27/2012	

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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and interview, the facility failed to ensure that a nurse executive be responsible for all areas where nursing personnel are required to provide patient care for one facility.</p>	S0912	<p><b>Actions Taken to correct deficiency: Revision to organizational chart with corresponding monthly meeting monthly and as needed for BHS Executive</b></p>	01/27/2012			

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	<p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility Organization Chart for Nursing Organizational Structure for Nursing Standards dated 01-23-2012 indicated that staff #43 was the Vice President of Nursing.</li> <li>On 01-23-12 at 1330 hours staff #43 confirmed that the facility had offsite 5 inpatient mental health units, Psychiatric Intensive Care Unit, Dual Diagnosis, Youth Services, Adult Affective Disorders and Serious Mentally Ill, that he/she is not responsible for the nursing activities.</li> <li>Review of the facility Organization Chart labeled CHE Structure Acute Care lacked documentation that staff #43 was responsible for the offsite 5 inpatient mental health units, Psychiatric Intensive Care Unit, Dual Diagnosis, Youth Services, Adult Affective Disorders and Serious Mentally Ill.</li> </ol>		<p><b>Nursing Director, Network CNO, and CHE VP Patient Services, to support standards and quality. Monitoring to prevent recurrence: _ Review of organizational chart as needed and at least annually. Responsibility: Network CNO, CHE VP patient services/CNE, BHS Executive Nursing Director Date of Correction:</b> Organizational chart revision 1/27/2012. Leadership discussed concern at the survey close on the final day of the survey. The COO for Acute Care Services, and the Network CNO discussed this issue with surveyor, John and recommendations were agreed upon to update the CHE organizational chart to include the 5 offsite inpatient mental health units, Psychiatric Intensive Care Unit, Dual Diagnosis, Youth Services, Adult Affective Disorders and Serious Mentally Ill.</p>		

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S0952	<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).</p> <p>Based on policy/procedure review, transfusion record review and staff interview, the facility failed to administer three of seven blood transfusions reviewed in accordance with approved medical staff policies and procedures.</p> <p>Findings included: 1. On 1/24/12 between 12:00 p.m. and 2:00 p.m., review of a policy/procedure titled: "Blood Component Administration, NPP#:14B1 Effective: 6/17/10" revealed "Policy Statements #13. Nursing will monitor the patient in the following ways, pre-, during, and post-transfusion: b. By obtaining Temperature, Pulse and Respirations(T-P-R) and Blood Pressure (B/P) before the transfusion. c. By performing an assessment for symptoms of a transfusion reaction and assessing patient's T-P-R and B/P at 15</p>	S0952	<p><b>Actions Taken to correct deficiency: Level 1 Actions</b></p> <p>1. Compile list of Deficiencies 2. Formulate Education Plan addressing Each Deficiency 3. Prepare Educational Powerpoint 4. Consult with stakeholders 5. Operationalize education plan 6. Evaluate effectiveness of Education through Compliance Auditing</p> <p><b>See Level 2 Actions in attached GridMonitoring to prevent recurrence: 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 Sovera.</b></p> <p><b>Ongoing process with follow up report to MACL and unit managers. Audit results reported at Transfusion and Blood Management Committee, Nursing /Laboratory meeting and IV Advanced Practice meeting by Blood Management</b></p>	01/27/2012			

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	<p>minutes into the transfusion."</p> <p>2. On 1/24/12 between 12:00 p.m. and 2:00 p.m. revealed:</p> <table border="1"> <thead> <tr> <th>MR#</th> <th>Start</th> <th>15 Min.</th> </tr> </thead> <tbody> <tr> <td>000620920</td> <td>19:53</td> <td>20:15</td> </tr> <tr> <td>000343766</td> <td>10:20</td> <td>10:30</td> </tr> <tr> <td>000035093</td> <td>14:10</td> <td>14:20</td> </tr> </tbody> </table> <p>MR# is the patient's medical record # and start is the time the transfusion started and the 15 min. is the time the second set of vitals was taken.</p> <p>3. In interview during the above review time, staff person #cp2 acknowledged the approved medical staff policies and procedures were not followed.</p>	MR#	Start	15 Min.	000620920	19:53	20:15	000343766	10:20	10:30	000035093	14:10	14:20		<p><b>Officer. Responsibility:</b> · Staff Nurses to comply with the Blood Administration policy to document at required intervals</p> <p>· MACL to audit transfusion record for accuracy · Managers to assure accuracy/correction of transfusion sheet · Blood Management Officer audits compliance, provides education and feedback to managers/committees</p> <p><b>Date of Correction: Initial education for corrective action began 11/11/11</b></p>	
MR#	Start	15 Min.														
000620920	19:53	20:15														
000343766	10:20	10:30														
000035093	14:10	14:20														

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S1118	<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 a condition which resulted in a hazard to patients, public or employees in 2 instances.</p> <p>Findings:</p> <p>1. On 1-23-12 at 11:55 am in the presence of employees #A10 and #A13, it was observed in the old boiler room there was 1 fire extinguisher on the floor unsecured by chain or holder. If the above extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>2. On 1-24-12 at 2:35 pm in the presence of employees #A15, it was observed in the hospital's Oncology department, there was an alcohol-based hand sanitizer (ABHS) on the wall directly over an</p>	S1118	<p><b>1. Actions taken to correct deficiency:</b>Actions (below) were in place prior to the SBOH inspection, however, we immediately secured the fire extinguisher at the time the deficiency was noted and re-educated (reminded) the contractors and security that the fire extinguishers must be secured at all times. Security does walkthroughs of the boiler room at least one time per night shift, and generally speaking during the day there is a maintenance employee in the vicinity who would be responsible for the area. Both departments are tasked with looking out for hazards such as this when they do their tours. <u>Monitoring to prevent recurrence:</u>The contractors have been educated to secure the fire extinguishers. We have temporary fire extinguisher boxes for construction areas that can be</p>	01/27/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
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	electrical outlet. It was also observed there was streaking down the wall from the dispenser toward the outlet that appeared to be the alcohol-based product from the dispenser. The direct positioning over an electrical outlet and the streaking, posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source.		moved when needed. The contractors have work carts with an extinguisher holder – this should help alleviate this issue. The contractor supervisors, maintenance, and security will monitor the fire extinguishers when making random rounds of construction areas, equipment rooms, and hospital floors. The security officers have been educated to remove unsecured fire extinguishers and document any issues in an incident report or on the monthly fire extinguisher list. The safety department will also check for unsecured fire extinguishers during safety assessments and random area inspections. Responsibility: Safety Administration, Security Manager and the Director of Facilities Engineering and Maintenance. Date of Correction: The deficiency was corrected 1/23/2012. <b>2. In regard to an alcohol-based hand sanitizer directly over an electrical outlet. Actions Taken to correct deficiency: Hand Cleanser and holder removed from wall 1/24/2012 Monitoring to prevent recurrence: Will not be replaced in dirty utility room. Responsibility: Director of Oncology Department Date of Correction: 1/24/2012.</b>	