

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/20/2012
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NAME OF PROVIDER OR SUPPLIER  INDIANA ORTHOPAEDIC HOSPITAL LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8400 NORTHWEST BLVD INDIANAPOLIS, IN 46278
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 003930</p> <p>Survey Date: 9-18/20-12</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 09/21/12</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 reports of quality monitoring activities for 1 contracted service.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the governing board minutes for calendar year 2011 indicated they did not include review of reports for the contracted psychology service.</li> <li>2. In interview, on 9-20-12 at 11:55 am, employee #A4 indicated no report for the contracted psychology service was reviewed by the governing board in calendar year 2011 and no further documentation was provided prior to exit.</li> </ol>	S0270	<p>Psychology contract indicator has been added to the contracted service quality assessment tracking sheet. This indicator will be monitored monthly for completion and compliance.</p> <p>Cindy Hoesman, QA manager will be responsible for this indicator as well as inpatient nursing staff</p>	10/02/2012

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S0312	<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.</p> <p>Based on document review and interview, the facility failed to conduct, per facility policy, a performance evaluation for 5 (PF#6, PF#8, PF#9, PF#11, and PF#12) of 10 employee files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the Employee Handbook, reviewed by the facility on 6-27-11, in a section entitled PERFORMANCE EVALUATION, indicated performance evaluations are generally performed on an annual basis.</li> <li>Review of 10 personnel files indicated contracted employee files PF#6, PF#8, PF#9, PF#11, and PF#12 had documentation of a current personnel</li> </ol>	S0312	HR will review all contracts and communicate to all managers with contracted/agency employees that they need to receive and sign an annual review. HR will conduct monthly audits of all contracted/agency files. HR director will be responsible.	09/28/2012	

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	<p>evaluation conducted by the contractor. However, the documentation did not indicated a performance evaluation done by the facility itself nor any documentation of review by an authorized hospital employee of the evaluation conducted by the contractor.</p> <p>3. In interview, on 9-20-12 at 1:45 pm, employee #A2 indicated there was no documentation for the above files of a performance evaluation done by the facility itself nor any documentation of review by an authorized hospital employee of the evaluation conducted by the contractor. No further documentation was provided prior to exit.</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 service 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 contracted service of psychology.</p> <p>2. In interview, on 9-20-12 at 11:55 am, employee #A4 indicated there was no documentation for the above activity and none was provided prior to exit.</p>	S0406	<p>Psychology contract indicator has been added to the Contract Services Quality Assessment Tracking Sheet. This indicator will be monitored quarterly for completion and compliance . Cindy Hoesman, Quality Manager will be responsible for this along with inpatient staff.</p>	10/02/2012	

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S0596	<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 and interview, the infection control committee failed to review and recommend changes in policy &amp; procedures for 1 V Pro sterilizer.</p> <p>Findings include:</p> <p>1. On 09-19-12 at 1000 hours during the facility tour of the Indiana Orthopaedic South offsite, the following was observed in the surgical services area: 1 V Pro sterilizer.</p> <p>2. On 09-21-12 at 1105 hours via telephone, staff #40 confirmed the facility did not have policy &amp; procedures for use of the V Pro sterilizer.</p>	S0596	A V-pro policy has been written and pended for approval. It will be reviewed by all members of the Infection Control Committee and forwarded for approval from Medical Executive Committee and the Board. Policies regarding sterilization equipment will be written and approved by Infection Control Committee prior to any new equipment being placed into service. The Director of Surgery and the Infection Control Practitioner will be responsible.	10/24/2012			

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S0868	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(M) A requirement that a complete physical examination and medical history be performed: (i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff; (ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or (iii) within forty-eight (48) hours after an admission.</p> <p>Based on document review and interview, the medical staff failed to follow its Medical Staff Governance Policy &amp; Procedure Manual for completing history &amp; physicals for 4 of 15 medical records (MR) reviewed (Patient #5, 9, 13 and 15).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Governance Policy &amp; Procedure Manual indicated the following: "3. A History and Physical: An H&amp;P should be documented within twenty-four hours of admission and prior to surgery.</p>	S0868	All medical staff members will receive periodic reminders of the guidelines and timeframes for H and P completion. All H and P's will be thoroughly reviewed prior to surgery to ensure compliance. Procedures shall not start until a completed H and P or updated H and P has been received. The surgery staff will contact HIM as needed for assistance. Meetings will be held for surgery and HIM staff to discuss the process and verify any opportunities for improvement. Non-compliant H and P's will be reported for review. Director of Surgery and Director of HIM will be	09/28/2012

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	<p>An H&amp;P performed within thirty (30) days before admission is acceptable if there is an appropriate updating entry within 24 hours of admission and prior to surgery indicating relevant changes between the exam and admission." This policy &amp; procedure was last reviewed/revised on 06-22-11.</p> <p>2. Review of patient #5's MR indicated the patient was admitted to the facility on 07-06-12 and the history &amp; physical was done on 05-09-12.</p> <p>3. Review of patient 9's MR indicated the patient was in surgery on 08-10-12 from 1023 hours to 1207 hours and the history and physical was done prior to admission and was updated by the physician on 08-10-12 at 1143 hours.</p> <p>4. Review of patient #13's MR indicated the patient's history &amp; physical was completed on 08-10-12 at 0050 hours. Patient #13's MR indicated the patient was admitted to the Indiana Orthopaedic West offsite outpatient surgery area on 08-10-12. The patient's MR indicated the preassessment by nursing was done on 08-10-12 at 0808 hours. The history &amp; physical lacked documentation of an update. It could not be determined that the patient was in the facility prior to 0808 hours on 08-10-12.</p>		responsible for adherence to this correction.				

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	<p>5. Review of patient #15's MR indicated the patient's history &amp; physical was completed on 08-10-12 at 0620 hours. Patient #15's MR indicated the patient was admitted to the Indiana Orthopaedic West offsite outpatient surgery area on 08-10-12. The patient's MR indicated the patient signed the general consent on 08-10-12 at 0818 hours. The history &amp; physical lacked documentation of an update. It could not be determined that the patient was in the facility prior to 0818 hours on 08-10-12.</p> <p>6. On 09-20-12 at 1515 hours, staff #42 confirmed that patients admitted to the outpatient surgery area usually get their general consent completed first.</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). Based on transfusion record review, policy procedure review, and staff interview, the facility failed to administer two of seven transfusions reviewed according to approved medical staff policies and procedures.</p> <p>Findings included: 1. Review of a transfusion administration policy labeled IOH Policy Stat ID: 153686, Effective Date: 03/2005, Approved Date: 05/2012 revealed: "D. Take the patients pre-transfusion vital signs to be recorded on the Blood Transfusion Record Form in the appropriate spaces. E. Once the blood is obtained, two individuals....." 2. Review of seven transfusion record forms revealed two transfusions, numbers T-2 and T-7 had recorded times for the previtals that were the same as the recorded times for the start of the transfusions. Since the policy says to do</p>	S0952	<p>Policy has been revised to make steps clear and concise for staff. Education and reinforcement of the policy has been completed to all staff administering blood and blood products that the pre-transfusion vitals time of record should be prior to the administration start time. The CNO did the education and the Lab Manager will track adherence to the policy.</p>	10/04/2012

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	<p>the previtals before obtaining the blood, the policy was not followed.</p> <p>3. On 9/18/12 between 1:00 p.m. and 2:00 p.m. staff person #7 acknowledged these were the recorded times.</p>				

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 2 pieces of equipment.</p> <p>Findings:</p> <p>1. In interview, on 9-18-12 at 2:10 pm, a physical staff therapist indicated a ladder, located in the outpatient physical therapy area, was for for patient care.</p> <p>2. On the above date and time, employee #A3 was requested to provide documentation of PM done on the ladder. The employee presented documentation of a PM which was done after the start of the survey. Thus, the PM had been done after the surveyor discovered there had been none prior to the survey.</p> <p>3. On 9-18-12 at 12:45 pm, employee</p>	S1164	<p>Both pieces of equipment had preventative maintenance completed and documented on 9.18.12. Both pieces of equipment have been added electronically to the Biomed annual checklist. A reminder was sent to all managers stating that if new patient care equipment was added, Biomed must be notified. The material management manager will be responsible.</p>	09/25/2012	

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	<p>#A3 was requested to provide documentation of a PM done on an incubator located in the pharmacy, QL-Model 10-140.</p> <p>4. In interview, on 9-20-12 at 1:30 pm, employee #A4 indicated there was no documentation of PM done on the incubator and no further documentation was provided prior to exit.</p>				