

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2021
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP COD 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000 Bldg. 00	<p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00347928</p> <p>Substantiated: Deficiency related to the allegation is cited.</p> <p>Date of Survey: 6/16/21</p> <p>Facility Number: 011437</p> <p>QA: 6/29/2021</p>	S 0000		
S 0912 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE</p> <p>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.</p>			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2021
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP COD 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.</p> <p>(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.</p> <p>(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 follow their policy ("Laboratory Testing-POC") and provide nursing standards of care for 1 of 5 patient complaints reviewed (PT4).</p> <p>Findings include:</p> <p>1) Review of policy titled, "Laboratory Testing-POC," policy #8169935, dated-06/2020, read on pages four and five of eight, "I. Credit Forms 1. Credit forms are used to document when a reported lab result needs a credit due to...incorrect results or any other detail that requires the attention of the point of care team...".</p> <p>2) Review of PT-4's lab result in the EMR (electronic medical record), indicated a negative urine pregnancy result on 4/6/20 at 13:21 hours and was an accurate result, but PT4 had a positive result recorded (incorrectly) after another patient was tested using PT4's identifying information and the final result reported was as a positive (incorrect) pregnancy result for PT4 in the EMR on 4/6/20 at 15:25 hours.</p>	S 0912	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>The lab result was corrected on the day of survey.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <p>The action plan contains several components and are listed below:</p> <p>1. The Emergency Department(ED) Leadership shared expectations of process for point of care lab errors with ED caregivers in daily huddles beginning June 24, 2021. The process was reinforced in the July 9, 2021 ED caregiver 'Weekly Wrap-Up' email.</p> <p>Content from July 9th Weekly Wrap-Up email: <u>POC errors- Please make sure</u></p>	08/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150169	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2021
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP COD 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3) Review of facility incident report read, "Clin lab notified by nursing unit that patient ID on specimen was incorrect...".</p> <p>4) Review of "Red Rule Investigation," read on page one of one, "Employee Involved: SP-3 (Emergency Room Technician)...Date of Violation: 4/6/2020...PACER Number: 14974...Description of Red Rule Violation: ...It can be deduced that SP-3 scanned the previous patients label when completing the pregnancy test on [different patient] and discovered her error and completed the scanning/test entry on the correct patient. It can also be deduced the red rule was not followed". SP-7 (Emergency Department Manager #2) spoke with SP-3 to ask if he/she remembered this incident and if he/she had reported it or completed a chart correction. SP-3 stated he/she did not recall the event and that he/she has not put in a chart correction for a lab reporting mistake. SP-7 went over the information that was provided by the investigation and the only way this error could have occurred was by scanning the wrong label and not following the red rule. SP-3 stated he/she understood".</p> <p>5) In interview on 6/16/21 at 10:42 am, SP-2 (Director of Quality) confirmed that SP-3 failed to follow their laboratory testing policy and complete a "credit form," when a lab result had been incorrectly reported on a patient (PT-4) and agreed with the "Red Rule Investigation" that was conducted.</p>		<p><i>you are completing the POC correction form when an error is made. This document is the way to make sure the erroneous result is credited and removed from the chart. (PCC please show staff the POC folder and forms)</i></p> <p>b. The Point of Care(aka AccuCheck) eLearning was updated June 9, 2021 in anticipation of the upcoming AccuCheck validations.</p> <p>c. All AccuCheck operators are currently in the process of completing annual testing validation. This began on July 7, 2021 and is scheduled to be completed on August 25, 2021.</p> <p>d. The Emergency Department Unit Based Educator has supplemented the July 2021 AccuCheck validation with an attestation form regarding the expectations for lab errors/credits/corrections/questionable results.</p> <p>e. The process for future events is as follows: In the event an error is discovered and no credit form was submitted; the ED Leadership will counsel the employee on process expectations; the employee will complete/submit the credit form; and the ED Leadership will verify the form was submitted and correction completed.</p> <p>3. Who is going to be responsible for numbers 1 and 2</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150169	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2021
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP COD 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			above; i.e., director, supervisor, etc.? Emergency Department Director 4. By what date are you going to have the deficiency corrected? August 25, 2021	