

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150128	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/19/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005109</p> <p>Survey Date: 8-15/18-11</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 09/06/11</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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S0178	<p>410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation, the hospital failed to conspicuously post the hospital license in an area open to patients and the public in 1 instance.</p> <p>Findings:</p> <p>1. On 8-17-11 at 9:30 am in the presence of employee #A5, it was observed at the Sleep Lab offsite thT there was no hospital license posted in an area open to patients and the public.</p>	S0178	<p>On 8/17/11, when the surveyor visited the Sleep Lab and noted the missing liscense being posted, it was immediatley rectified, and the sign was posted that same day by the manager of the Sleep Lab. No further monitoring is needed.</p>	08/19/2011			

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S0406	<p>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 review of documents, the hospital failed to include 5 services directly-provided by the hospital and 5 services provided by a contractor as part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings:</p> <p>1. Review of the facility's QA&I program indicated it did not include the directly-provided service of Cardio Rehab, Pediatrics, Recovery Room, Rehabilitation Services and Rehab & Sports Medicine South offsite.</p> <p>2. Review of the facility's QA&I program indicated it did not include the contracted services of biohazardous waste, blood bank, dietary, lithotripsy and tissue transplant.</p> <p>2. On 8-17-11 at 2:30 pm, employee #A1</p>	S0406	<p>All areas of non-compliance have plans in place to achieve compliance as evidenced below:1. Cardio Rehab: All patients being admitted with a diagnosis of CHF, will have an alert printed and sent to the Cardio Rehab department manager, who will then review the case and deem if rehab services are warranted for this patient per Community Health Network Guidelines for CHF patients.2. Pediatrics: As falls in the Pediatric population is an area that has been deemed important to monitor as a quality measure, beginning October 1, 2011, case reporting/review will be implemented in the Pediatric Unit at CHS.3. Recovery Room: Beginning October 1, 2011, auditing of Recovery patients will begin. Each week, 5 charts will be randomly reviewed to insure that VS are being completed and documented Q15 mins X1 hour in the first hour of recovery per</p>	09/19/2011			

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	was requested to provide the above documentation and none was provided prior to exit.		Community Health Network Guidelines for post-operative patients. 4. Rehabilitation Services and Sports Medicine: Beginning October 1, 2011, review of services on patients will be completed to insure that all necessary documentation is included in the record, and that charges are being evaluated for errors. 5. Contracted services: Biohazardous waste-tracking pounds per patient days. Blood bank-blood product turn-around-time. Dietary-customer satisfaction is now being monitored through the HCAHPS report. Lithotripsy-documentation of current service in preventative maintenance on equipment. Tissue transplant-all biological tissues received for transplant will arrive in appropriate container, correctly labeled, required temperature from an accredited vendor. These areas of review will be done per managers for the Cardiac Rehab, Pediatric, Recovery Room, Rehab and Sports Medicine, and the contracted services of blood bank, dietary, lithotripsy, tissue transplant, and biohazardous waste and ongoing compliance will be monitored by the respective Managers.		

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S0554	<p>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 interview and document review, the hospital created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the manufacturer's instructions for monitoring of CIDEX OPA Solution, a high level disinfectant for reprocessing heat sensitive reusable semi-critical medical devices, indicated during reuse, it is recommended that the CIDEX OPA Solution be tested with CIDEX OPA Solution Test Strips prior to each use. Review of the log book used to document use of the Test Strips for ultrasound probes indicated the Strips were used once per day. On 5-15-11 at 11:05 am, upon interview, employee #A7 indicated when CIDEX OPA was used to clean probes, the solution was tested with a CIDEX OPA Solution Test Strip once per day. 	S0554	<p>The Infection Control Policy for CHI standards for cleaning, high level disinfection, sterilization, sterilization and packaging materials have been changed to state "test the high level disinfectant according to manufacturers recommendations. For Cidex OPA, this check is to be done prior to EACH use". Education to users to follow manufacturers recommendations occurred 9/3/11, with a thermometer and timer initiation that was implemented on 9/15/11. This policy goes to the Network Committee at their next meetings on November 4th and November 23rd for final approval. Ongoing compliance with the policy is the responsibility of the Manager.</p>	09/03/2011	

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	Upon further interview, the employee indicated if the same solution was used more than once per day, there would be no further test strip checks.			
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S0570	<p>410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on document review and interview, the facility failed to follow established Medical Staff Bylaws for Infection Control Committee composition.</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Bylaws on page 38 indicated the following: "10.8 Infection Control Committee 10.8-1 Composition The Infection Control Committee shall consist of at least nine (9) members including representatives from the Departments of Internal Medicine,</p>	S0570	<p>Actions:1. The Chief of the Medical Staff has reviewed the Medical Staff bylaws for the Infection Control Committee. He will make new appointments as necessary to the CHS Infection Control Committee starting in October. 2. A member of the Infection Control Committee is Richard Bohenkamp, M.D. He is the CHS Chief of Medical Staff and has regularly attended the Infection Control Committee. He is considered a part of the CHS Administration. 3. A member of the Infection Control Committee is Randall Lee M.D. who is the Vice President of</p>	09/19/2011			

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	<p>Surgery, OB/GYN, Pathology and Family Practice; Nursing Service, Administration and an individual employed in a surveillance or epidemiological capacity."</p> <p>2. Review of the Infection Control Committee Meeting minutes indicated the following: at the 08-25-10 meeting no medical staff representative from Family Practice, Pathology, Surgery and OB/GYN and no Administrative representative. at the 12-08-10 meeting no medical staff representative from Pathology, Surgery and OB/GYN and no Administrative representative. at the 02-23-11 meeting no medical staff representative from Surgery and OB/GYN and no Administrative representative. at the 05-25-11 meeting no medical staff representative from Surgery and OB/GYN and no Administrative representative.</p> <p>3. On 08-18-11 at 1450 hours, staff #41 & 42 confirmed that the above Infection Control Committee members were not present.</p>		<p>Medical Affairs for CHS. He is part of CHS Administration. He has been in attendance at all the meetings starting in May 2010. 4. Marcia Anness, Vickie Hacker and Linda Herrmman all attend and at various times have stated they were representing Kerry Sawin, Vice President of Nursing and part of the CHS Hospital Administration. Attendance compliance will be achieved in the following manner: 1. Give each new member the meeting schedule and ask that they attend. Re-evaluate attendance at the Medical Executive meeting that occurs monthly. 2. Make sure the sign-in sheet has the correct titles for all members. 3. Capture in the minutes and on the Attendance sheet that a Nursing Director is attending for the Vice President of Nursing. Responsible Parties for implementation and ongoing compliance with the standard include: Chief of Medical Staff, and Infection Control Preventionalist for CHS. Completion date for this is: October 1st, 2011.</p>		

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S0732	<p>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 the facility failed to ensure that the medical record (MR) contains sufficient information to document accurately the course of treatment and results for 1 of 2 death MRs reviewed (Patient #19).</p> <p>Findings include:</p> <p>1. Review of patient #19's MR Multidisciplinary Note dated 03-25-11 at 0516 hours indicated the following: "Body released to mortuary representative." Review of patient #19's MR the Physician's Discharge Summary dated 07-08-11 at 1352 hours indicated the following; "To the ECF for the end of life care with comfort measures only."</p>	S0732	A thorough review of the record was completed. The physician that dictated the original Discharge Summary is no longer a practicing physician at Community Hospital South. Per Medical Record Services, this record will be closed with a notation that this record cannot be completed due to the physician no longer having privileges in this hospital. Medical record monitoring is the responsibility of the Health Information Management Department and audits will be done periodically to assure the medical record is complete.	09/13/2011	

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S1020	<p>410 IAC 15-1.5-7 (d)(2)(A)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on interview and document review, the hospital failed to ensure the monthly inspection of 1 area where medications were stored.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 8-15-11 at 11:40 am, upon interview, pharmacy staff indicated the Pharmacy conducted monthly inspections of all areas in which medications were stored. On that same date and time, the staff member was asked if there are any medications stored in the Cardiac Cath Lab. The staff member indicated affirmatively. On that same date and time, the staff member was requested to provide documentation of the monthly checks in that area. 	S1020	<p>Effective September 1st, the Pharmacy Director revised the inspection documentation to verify that all areas will be inspected monthly. Prior to the end of each month, the Pharmacy Director will review documentation and verify that the inspections have been completed. Failure to complete inspection prior to the end of the month will result in disciplinary action. Responsible individual for compliance: Director of Pharmacy.</p>	09/01/2011	

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	<p>4. Review of a document entitled PHARMACY INSPECTION REPORT, indicated there was a report for CATH 1, dated 4-25-11, time @1925.</p> <p>5. The staff member was requested to provide documentation of PHARMACY INSPECTION REPORTS for May, June and July, 2011. The staff member indicated there were no reports for those months and no documentation was provided prior to exit.</p>			
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S1118	<p>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, document review and interview, the hospital created a condition which resulted in a hazard to patients, public or employees in 3 instances.</p> <p>Findings:</p> <p>1. On 8-15-11 at 12:03 pm in the presence of employees #A4, #A5 and #A6, it was observed on facility tour, patient room 3707 could be used as a negative air pressure room.</p> <p>2. On that same date and time, employee #A4, upon interview, indicated once the automatic negative air pressure measuring device detected a pressure outside pre-set limits, an alarm would occur and Nursing would make a telephone call to notify Maintenance the alarm was triggered. The employee further indicated a Maintenance staff would arrive within</p>			S1118	<p>S1118 Physical Plant: Negative Air Alarm, Findings 1-3.</p> <p>At the direction of the surveyor, the room air pressure alarm was activated and the nurse phoned for a service request by maintenance. Staff stated their assumption that maintenance would respond in about 5 minutes. At the direction of the surveyor, the nurse then cleared the alarm. When the alarm was initially activated, maintenance was alerted automatically via the building control system. Maintenance also received the call from the nurse. However, when the alarm was cleared by the nurse, a message was again automatically sent by the building control system notifying the mechanic that the alarm was cleared. The mechanic, thinking the alarm was cleared and the room was back to normal, responded back in about 15 minutes to confirm the room status. Maintenance does not have a</p>		08/19/2011

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	<p>about 5 minutes to attend to respond to the alarm.</p> <p>3. On 8-15-11 at 12:04 pm, it was observed the alarm was activated and a nurse made a telephone call to Maintenance to notify them the alarm was triggered. By 12:15 pm, there was no response by Maintenance to the telephone call.</p> <p>5. Review of the hospital's Safety Manual, indicated there was a section entitled COMPRESSED GAS SAFETY. This section indicated <u>cylinders must be stored in an upright position and secured by chain or holder or other appropriate means.</u></p> <p>6. On 8-15-11 at 12:30 pm in the presence of employees #A4, #A5 and #A6, it was observed in the Biomedical Engineering Work Room there was 1 fire extinguisher on the floor unsecured by chain or holder.</p> <p>7. On 8-15-11 at 1:50 pm in the presence of employees #A4, #A5 and #A6, it was observed in the Boiler Room there was 1 fire extinguisher on the floor unsecured by chain or holder.</p>		<p>policy stating a specific response time to this alarm as circumstances and schedules very widely from day-to-day. It is generally expected that maintenance will respond to any service call within 5-10 minutes either in person or by phone. Had this been an actual failure of the negative air system, maintenance would have work with nursing to relocate the patient to another isolation room as soon as possible or provide alternate means of pressure control (maintenance policy CHS UT401). These steps are also referenced in the infection control policies ICP 1-B and ICP 21. We believe our process remains solid and response times are appropriate. S1118 Physical Plant: Compressed gases, Finding 6.</p> <p>·Fire Extinguisher was found unsecured in the Clinical Engineering office. The extinguisher was secured the day of the survey 8/19/2011. This room had been recently renovated and the extinguisher was scheduled to be reinstalled. S1118 Physical Plant: Compressed gases, Finding 7.</p> <p>·Fire Extinguisher was found unsecured in the Boiler Room. The extinguisher was secured the day of the survey 8/19/2011. The Extinguisher had recently been moved due to construction activities in the area and was scheduled to be reinstalled.</p>		

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S1128	<p>410 IAC 15-1.5-8(c)(1)</p> <p>(c) In new construction, renovations, and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(1) The 2001 edition of the national "Guideline for Construction and Equipment of Hospitals and Medical Facilities" (Guidelines).</p> <p>Based on document review and observation, the hospital did not meet the 2001 edition of the national "Guideline for Construction and Equipment of Hospitals and Medical Facilities" for 1 room.</p> <p>Findings:</p> <p>1. Review of Section 7.28.B8 of the 2001 edition of the AIA national <u>Guideline for Construction and Equipment of Hospitals and Medical Facilities</u> indicates:</p> <p>Ceiling finishes in semi-restricted areas such as ... specialized radiographic rooms must be smooth, scrubable, non-absorptive, non-perforated, capable of withstanding cleaning with chemicals, and without crevices that can harbor mold and bacterial growth. If lay-in ceiling is provided, it shall be gasketed or clipped down to prevent the passage of particles</p>	S1128	<p>S1128 Physical Plant: Semi-restricted Ceilings Finding 2.</p> <p>The Interventional Radiology room is equipped with a clipped lay-in ceiling with non-perforated tiles. Upon inspection by maintenance, several tiles near the door were found with clips removed. Clips were reinstalled and the entire ceiling inspected on 8/31/2011. Ongoing compliance with the guidelines remains the responsibility of Maintenance and periodic checks of clips will be performed to assure compliance.</p>	08/19/2011			

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	<p>from the cavity above the ceiling plane into the semi-restricted environment.</p> <p>2. On 8-15-11 at 11:20 am in the presence of employees #A4, #A5 and #A6, it was observed that upon pushing on a laid in ceiling tile in the Interventional Radiology Room the tile was not gasketed or clipped down.</p>			
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S1168	<p>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 properly keep a discharge log for 1 of 1 defibrillators.</p> <p>Findings:</p> <ol style="list-style-type: none"> For defibrillators used on hospital crash carts, review of the manufacturer's handbook for the Zoll M Series Manual defibrillators indicated the following operational checks should be performed at the beginning of every shift. It further indicated to refer to the appropriate Operator's Shift Checklist [for the operational checks]. On 8-15-11 at 9:30 am during the entry conference, hospital staff indicated there were three (3) shifts of personnel per day. On 8-15-11 at 10:30 am, upon interview, a Radiology staff person indicated the department was open 7 days a week, 24 hours per day. Review of a document entitled Zoll 	S1168	<p>COMMUNITY HOSPITAL DISAGREES WITH THIS DEFICIENCY AND HAS INCLUDED AN IDR FORM-- -PLEASE SEE EXPLANATION BELOW:Response for S1168 - Community Hospital South is operating in accordance with Community Health Network Corporate Clinical Policy CLN-2005 Cardiopulmonary Resuscitation, last reviewed 4/26/2011, which references specific manufacturer recommendations for the Zoll M Series Defibrillators, and has been since the devices were installed across the Community Health Network. The same process for the daily testing of the defibrillators has been in place since 2005, and has been deemed to be adequate in numerous prior regulatory surveys. A specific inquiry regarding the recommended testing of the Zoll defibrillators was made by Community Health Network, when the defibrillators were purchased. To that inquiry, Zoll responded in writing on December 28, 2005 that the</p>	08/19/2011	

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	ACLS & BLS Units Crash Cart Signature Log, Location Main [Radiology], August, 2011, indicated the operational checks were done once per day.		defibrillators should be tested a minimum of once per 24 hour period, and that the checklist in the operator's manual is a general guideline which each facility can use in a way that best fits their needs. A copy of this letter is on file with the Community Health Network and has been included in this response. See Attachment A. ***** **** Addendum 1/30/12: IDR request denied. Plan of correction: The policy has been changed per the attached draft. It is being routed for approval, then training will happen for all affected employees. Such training will be documented. The crash cart forms will be updated to allow for the additional checks to be documented. The anticipated date of completion for policy approval is February 15th, 2012. The anticipate date of completion for the training is February 24 th , 2012. Subsequently, the organization will evaluate options to replace the M Series defibs with the new R series units, for which the manufacturer does require checking them once per shift. See attached policy revised Jan 2012.		