

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 09/23/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 011437</p> <p>Survey Date: 9-19/22-11</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/31/11</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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S0330	<p>410 IAC 15-1.4-1(c)(6)(K)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</p> <p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review and interview, the hospital failed to maintain personnel records for 2 of 11 employee files reviewed which included evidence of post offer and subsequent physical examinations.</p> <p>Findings:</p> <p>1. Review of Policy Number: 1F, entitled Employee Occupational Health Service (EOHS) Program, indicated the Employee Occupational Health Service (CHE) will schedule pre-placement medical examinations for all new employees.</p> <p>2. Review of 11 employee personnel files indicated files PF#1 and PF#2 lacked any</p>	S0330	<p>Background:Employee Occupational Health Services (EOHS) changed its new hire pre-placement "health examination /assessment" process to a "health screening" procedure in January 2011. The corresponding policy revisions to support the pre-placement change from "Health Exam to Health Screen" while discussed and vetted between EOHS and Human Resources (HR) lingered in terms of formal enactment and posting. As a result, the 2011 pre-placement process change was not in alignment with the posted EOHS Policy 1F at the time of the ISDOH survey at Community North Hospital in September 2011. Corrective Action based on ISDOH</p>	10/21/2011
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	<p>documentation of pre-placement medical examinations.</p> <p>3. On 9-21-11 at 2:30 pm, upon interview, employee #A10 indicated there was no documentation for the above-two employees and no documentation was provided prior to exit.</p>		<p>Citation: The attached revised EOHS Policy 1F is to be enacted and posted November 2011. The revised policy brings into alignment both (EOHS policy and EOHS process) for new hire pre-placement "health screenings" for all employees (regular and contract). Ongoing Monitoring and Evaluation: Periodic review of employee review of employee files will be done to ensure compliance to policy as indicated. Responsible Person: Director of Human Resources, Community Hospital North. Addendum: (12/2/11) Weekly audits of HR files including all employees (regular and contract) will be conducted to assure compliance with ISDH standards and internal policy. Non-compliant employees will not be allowed to work until pre-placement Health exam/assessment is completed and on file. Findings of audits will be forwarded to appropriate Human Resource Leadership and oversight committees.</p>		

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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 document review and interview, the hospital failed to include 2 services provided by a contractor to the hospital, 10 services provided by a contractor to the Hook's Rehab offsite and 11 contracted services to the Hook's Brain Injury offsite as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's QAPI program for Community North Hospital indicated it did not include the contracted services of biohazardous waste and laundry. On 9-22-11 at 3:00 pm, upon interview, employee #A6 indicated there was no documentation of the 2 above-stated contracted services having been included in the hospital's QAPI program and no other documentation was 	S0406	<p>Items 1 & 2 Corrective Action based on ISDOH Citation: The existing indicators for biohazardous waste and laundry will be changed for 2012. Currently these indicators are volume indicators. Beginning in 2012, we will post data on the timely and accurate completion of biohazardous waste paperwork through our contracted service and data summarizing the damaged or unacceptable linens that are returned to our laundry service. Ongoing Monitoring and Evaluation: These indicators will be posted quarterly and reviewed via the QA review process for CH-North Responsible owners: Jim Fortin, Directory of Environmental Service, Community Hospital North. Beth Kanzler, Director of Material Management CH-network. Items 3, 4 & 5 Corrective Action based on ISDOH Citation: Discharge planning is no longer a contracted</p>	10/21/2011			

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	<p>provided prior to exit.</p> <p>3. Review of the hospital's Master Contract and Addendums indicated Community Hospital East would provide contract services to the Hook's Rehab offsite including but not limited to, bioengineering, biohazardous waste, dietary, discharge planning, emergency department, housekeeping, laboratory, laundry, maintenance, radiology and respiratory therapy.</p> <p>4. Review of the facility's QAPI program for the Hook's Rehab offsite indicated it did not include the contracted services of bioengineering, biohazardous waste, dietary, discharge planning, emergency department, housekeeping, laboratory, laundry, maintenance and radiology.</p> <p>5. On 9-22-11 at 3:00 pm, employee #A6 indicated there was no documentation of the 10 above-stated contracted services for the Hook's Rehab offsite having been included in the hospital's QAPI program and no other documentation was provided prior to exit.</p> <p>6. Review of the facility's QAPI program for the Hook's Brain Injury offsite indicated it did not include the contracted services of bioengineering, biohazardous waste, dietary, discharge planning,</p>		<p>service for the Center. Social workers who perform discharge planning were made a part of the Center's administrative staff on 10/17/11. Dietary and Housekeeping services for both units will be monitored through the Center's patient satisfaction tool, Uspeq. Bioengineering, biohazardous waste, emergency department, laboratory, laundry, maintenance radiology, respiratory therapy and any other services purchased from the hospital for both units will fall under the QA/PI indicators and plans used by the hospital.</p> <p>Ongoing Monitoring and Evaluation Services will be monitored through the Center's patient satisfaction tool, Uspeq. Based on historic performance, goals will be developed and will be measured on a routine basis. PI plans will be developed to assist in increasing scores. Hospital monitored indicator performance monitoring will be utilized to ensure these services are monitored and improvement plans are put in place as required as a subset of the hospital's QA Program. Responsible owner: Doug Beebe, Executive Director Hook Rehab Facilities</p>		

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	<p>emergency department, housekeeping, laboratory, laundry, maintenance, radiology and respiratory therapy.</p> <p>7. On 9-22-11 at 3:00 pm, employee #A6 indicated there was no documentation of the 11 above-stated contracted services for the Hook's Brain Injury offsite having been included in the hospital's QAPI program and no other documentation was provided prior to exit.</p>			
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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 observation and document review, the facility failed to minimize infection exposure by adhering to proper hand washing practices in the kitchen, failed to follow hospital policy in using a disinfecting solution no more than 14 days without changing it in 4 of 9 instances and failed to remove expired items from stock.</p> <p>Findings included:</p> <p>1. Retail Food Establishment Sanitation Requirements 410 IAC 7-24-129 states, "Food employees shall clean their hands and exposed portions of their arms as specified under section 128 of this rule immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: After touching bare human body parts other than clean hands and clean, exposed portions of arms; After using the toilet room; After coughing, sneezing, or using a handkerchief or disposable tissue; After drinking, other than as specified in section</p>	S0554	<p>Item 1: Corrective Action based on ISDOH Citation: Infection control will conduct an inservice on handwashing at next Nutrition and Food Services Department (NFS) inservice for all staff. All staff will sign off as being trained and notified of expectations. Ongoing Monitoring and Evaluation: The staff in NFS will conduct 30 handwashing observations per month to the Infection Prevention team observations. Infection Control will keep a database and monitor compliance. First set of observations to be completed and submitted to Infection Prevention team by 12/5/2011. Subsequent monthly observations due the 5 th of each month. Responsible Person: Infection Prevention Specialist CH-North and Director of Food and Nutrition Services Community Hospital North. Item 2: Corrective Action based on ISDOH Citation: Infection control will conduct an inservice on handwashing at next Nutrition and Food Services Department (NFS) inservice for all staff including content on washing hands prior to changing . All staff will sign off as being trained and notified of expectations. Include a</p>	10/21/2011	

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	<p>136(b) of this rule, using tobacco, or eating; After handling soiled surfaces, equipment, or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks; When switching between working with raw food and working with ready-to-eat food; Before touching food or food-contact surfaces; Before placing gloves on hands; After engaging in other activities that contaminate the hands."</p> <p>2. At 10:30 AM on 9/19/2011, the kitchen and cafeteria were inspected. A staff member was observed using a meat slicer and slicing deli turkey. The staff member was observed catching the shaved deli turkey with his/her left hand that had a cutting glove on it. After the staff member was questioned on the sanitation of the cutting glove, the staff member put on the latex glove without washing his/her hands and before the cutting glove was proper washed, rinsed and sanitized. The handwashing sink for the salad bar station was observed not dispensing water for handwashing. Staff were observed changing gloves without washing their hands first. Gloves were observed on the prep counter in the salad bar area. A room service food service staff member was observed changing gloves three times without washing hands</p>		<p>daily assignment of adding fresh water to free standing sink to ensure fresh water in sufficient quantity is always available in this sink. Additionally, alcohol sanitizing foam has been placed in the area in the case of emergency malfunction of the portable sink. A staff inservice on proper storage, sanitation, cleaning, usage and upkeep of chain mail cutting glove was conducted on 10/12/2011. This educational presentation will be repeated one time per week for 4 consecutive weeks until all staff are trained and sign off as being trained. Content of inservice included new process is to store glove in clean bag in the manager's office and sealed. Glove is still deemed "dirty," until removed from the office, washed and sanitized. The process includes wearing a vinyl glove under and over the chain mail cutting glove. After the glove is used, proper washing and sanitizing is required. Afterwards, it is placed back in a new clean bag for storage until the next use. Ongoing Monitoring and Evaluation: The staff in NFS will conduct 30 handwashing observations per month to the Infection Prevention team observations. Infection Control will keep a database and monitor compliance. First set of observations to be completed and submitted to Infection Prevention team by 12/5/2011. Subsequent</p>		

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	<p>first. Three other staff members located in the production area and the cafeteria were observed changing their gloves without washing their hands first.</p> <p>3. Review of hospital policy DPP NO: US-3. entitled MEDICAL IMAGING STANDARDS FOR CLEANING, DISINFECTING AND DRYING THE INTRAVAGINAL AND/OR INTRACAVITY PROBES, indicated the Cidex OPA placed in the probe disinfecting container must not be used beyond 14 days or if the solution does not pass the test strip test.</p> <p>4. Review of a document entitled Cidex OPA log indicated for the time period March 22, 2011 through September 20, 2011, the date Cidex changed was as follows:</p> <p>March 22 and April 19 - 28 days April 19 and May 3 - 14 days May 3 and May 31 - 28 days May 31 and June 14 - 14 days June 14 and June 28 - 14 days June 28 and July 12 - 14 days July 12 and August 9 - 28 days August 9 and August 23 - 14 days August 23 and September 20 - 28 days</p> <p>5. During a tour of the Surgery Department on 9/20/11, the following items were found:</p>		<p>monthly observations due the 5 th of each month. Monthly infection prevention rounds will include observations on the availability of fresh water for the portable sink and correct packaging of the chain mail cutting glove.</p> <p>Responsible Person: Infection Prevention Specialist CH-North and Director of Food and Nutrition Services Community Hospital North. Item 3: Corrective Action based on ISDOH</p> <p>Citation: Re-educated recent tech that transferred into department to follow manufacturer's recommendation's for Cidex OPA. Ongoing Monitoring and Evaluation: The log will be checked during the infection prevention rounds. Monthly check by chief technologist or delegated staff. Responsible Person: Director of Imaging Center Item 5: Corrective Action based on ISDOH</p> <p>Citation: A new job has been created titled "anesthesia coordinator." One of the responsibilities of this new role will be the checking inventory and supplies. This includes a weekly documented check on outdates on the Malignant Hyperthermia Carts. Until this position is filled, the Director will assign this duty to a staff member each week.</p> <p>Ongoing Monitoring and Evaluation: The log will be reviewed by the Director quarterly for compliance as well as "spot</p>				

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	<p>a. On the Malignant Hyperthermia cart: one 500cc IV bag of NS - expired 9/1/11.</p> <p>b. On the Malignant Hyperthermia cart: one Arrowgard Blue Plus Multilumen CVC kit - expired 8/2011.</p> <p>2. During a tour of the Hook's Rehab brain injury unit on 9/20/11, the following items were found:</p> <p>a. In drawer #3 of the crash cart: one Actasept Central Line Dressing Change Kit - expired 8/2011.</p> <p>b. In drawer #3 of the crash cart: two IV start kits - expired 8/2011.</p> <p>3. During a tour of the Emergency Department on 9/19/11, the following items were found on the Broselow/pediatric crash cart:</p> <p>a. One package of ConMed Huggables Neonatal/Pediatric ECG Electrodes (3 per package) - expired 2-2011.</p> <p>b. Two Cardinal Health Illinois Bone Marrow Needles - one expired 6-2011, one expired 8-2011.</p> <p>c. Two B-D Insyte Autoguard IVs (one 18 gauge and one 20 gauge) - expired 6-2011.</p> <p>d. One IV Start Kit - expired 8-2011.</p> <p>e. Two Rusch Duodenal tubes - one expired 1-2011, one expired 8-2011.</p> <p>f. Two packages of fougera surgilube ointment - one expired Jan11, one expired May11.</p> <p>g. Two Arrow Multilumen CVC kits - one expired 12/2010, one expired 7/2011.</p> <p>h. Eleven Microtainer baby blood tubes (mint green tops) - four expired 4-2011, seven expired 6-2011.</p>		<p>checks" during environmental rounds of the department.</p> <p>Responsible Person: Director of OR Services.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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S0748	<p>410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3).</p> <p>Based on medical record review, review of the hospital's Medical Staff approved bylaws and rules, and interview, the facility failed to ensure that entries in the medical record were authenticated promptly in 8 of 24 medical records.</p> <p>Findings include:</p> <p>1. On 9/21/11, during a random review of medical records of patients at the facility in the past 12 months, the following were found:</p> <p>a. Pt. #11 had outpatient surgery at the facility on 8/11/11. The Operative Note was not signed by the physician/surgeon.</p> <p>b. Pt. #11 was discharged on 8/8/11 and the Discharge Summary was not signed by the physician.</p> <p>c. Pt. #19 had orders written on 8/9/11 at 2225 that were not authenticated by the physician. Pt. #19 also had "Post-Op Major Abdominal Orders" (3 pages) - Page 1 was not dated or timed and Page 2 was not dated, timed, or signed by the physician.</p> <p>d. Pt. #20 had orders written on 8/11/11 at 2155 that were not authenticated by the physician.</p> <p>e. Pt. #21 was a patient at Hook's Rehab and had 3 pages of pre-printed Admission Orders dated 7/26/11 at 1815 - Pages 1 and 2 were not authenticated by the physician and</p>	S0748	<p>Corrective Action based on ISDOH Citation: A memo was sent to all medical staff. A transcription back log from mid-year 2011 has been eliminated making all dictated reports available for timely signature. With the back log eliminated, the policy for completion of records/signatures will be enforced via the hospital policy. Suspension for incomplete charts will be continued and strengthened.</p> <p>Ongoing Monitoring and Evaluation: Chart discrepancies will be reviewed monthly by the Director of Health Information Management with suspension being initiated at the medical staff level Responsible Person: Director Health Information Management</p>	10/21/2011			

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	<p>Page 3 was not signed or authenticated by the physician. Medication orders written by the RN dated 7/26/11 at 1815 were not authenticated by the physician. An insulin order written by the RN on 7/26/11 at 2320 was not authenticated by the physician. A pre-printed order page dated 7/26/11 regarding blood sugars and insulin was not authenticated by the physician. An order written by the RN on 7/27/11 at 2310 was not authenticated by the physician.</p> <p>f. Pt. #22 had orders written by the RN on 8/2/11 at 2240 that were not authenticated by the physician. The patient also had 3 pages of pre-printed Admission orders dated 8/2/11 at 2240 and none of the 3 pages was authenticated by the physician. Pt. #22's Discharge Summary was not signed by the physician.</p> <p>g. Pt. #23 came to the hospital for surgery. On 8/9/11, the "Patient's Consent For Surgery And/Or Other Treatment" was not signed by the physician indicating that he/she had discussed the benefits, risks, alternatives, and potential complications with the patient. Also, the Operative Note was not signed by the physician.</p> <p>h. Pt. #24 was discharged from the facility on 8/8/11 and the Discharge Summary was not signed by the physician.</p> <p>2. Medical Staff bylaws for the facility "Community Hospitals of Indiana, Inc. Community Hospitals East and Community Hospital North Medical Record Chart Requirements Inpatient & Medical Observation", under "Contents of the Medical Record" included "All entries in the</p>			
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	<p>medical record must be legible, complete, dated, timed, and authenticated either in written or electronic form."</p> <p>3. A#1 was present on 9/21/11 during review of the records and confirmed the findings.</p>			
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S0952	<p>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 medical record review, policy/procedure review, and interview, the facility failed to ensure that blood and blood product transfusions were administered according to hospital policies for 5 of 7 blood transfusions.</p> <p>Findings include:</p> <p>1. On 9/22/11, during medical record review of patients who had received blood and/or blood product transfusions within the last 12 months, the following were found:</p> <p>a. The blood consent for Pt. #6 did not include the physician's name, indicating that he/she had spoken to the patient/patient representative to inform them of the need for the blood transfusion. Also the telephone consent to transfuse blood for Pt. #6 was received from the patient's daughter and indicated the daughter was the patient's POA (power of attorney). Pt. #6's medical record contained no advance directive indicating a POA.</p> <p>b. Pt. #8 was admitted to the Daybeds unit for blood on 4/25/11 at 1325 per his/her facesheet. A Multidisciplinary Note written by an RN indicated that Pt. #6 arrived on</p>	S0952	<p>Corrective Action based on ISDOH Citation: Summarize details of each listed deficiency, formulate an education plan to each specific finding, develop education roll out plan with lab/nursing committee and Blood Transfusion committee. Blood transfusion education is a yearly educational requirement, so this additional focus will be included in that yearly requirement. Ongoing Monitoring and Evaluation: Random audits of 10-15% of transfusion records will be done with emphasis on identified deficiencies to trend over time. Additionally, each identified deficiency will shared with clinical leader for staff mentoring and follow up. Responsible Person: Network Blood Management Officer.</p>	10/21/2011			

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	<p>4/25/11 at 1330. The Transfusion Record documentation indicated that the blood was transported on 4/25/11 at 1310. It then was documented that the blood was started on 4/25/11 at 1224 (before the patient arrived to the unit). Pre-transfusion vitals documented as being done at 1415, blood documented as being started 4/25/11 at 1224, vitals at 15 minutes documented as being done at 1445, blood documented as being stopped at 1648, post-transfusion vitals documented as being done at 1648.</p> <p>c. Pt. #9 received platelets and blood on 4/1/11. The blood consent did not include the physician's name, indicating that he/she had spoken to the patient to inform them of the need for the blood transfusion. Platelets documented as being started 4/1/11 at 1700, post-transfusion vitals documented as being done at 1740, platelets documented as being stopped at 1742 (vitals done before platelets stopped). Blood documented as being started 4/1/11 at 1742, transfusion vitals at 15 minutes documented as being done at 1800, blood documented as being stopped at 2010, and post-transfusion vitals documented as being done at 2000 (10 minutes before blood stopped).</p> <p>d. Pt. #10 received platelets on 9/14/11. The Transfusion Record indicated that the platelets were transported 9/14/11 at 1140 and started at 1145, pre-transfusion vitals documented as being done at 1153 (after platelets started). Also, transfusion temp at 15 minutes documented as being 94.4 and post-transfusion temp documented as being 97.4 (increase of 3 degrees). According to</p>			
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	<p>Transfusion Record, if temp increases 2 degrees or more, physician to be notified. No documentation that physician notified.</p> <p>e. Pt. #11 received blood transfusion on 9/7/11. Transfusion Record documentation indicated that blood was started on 9/7/11 at 1215, vitals at 15 minutes documented as being done at 1220.</p> <p>2. Community Hospitals of Indiana, Inc Corporate Nursing Policy and Procedure "Blood Component Administration", NPP#: I-14B1, Effective: 6/17/10 included, on Page 3 "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...and assessing patient's T-P-R and B/P at 15 minutes into the transfusion. e. By obtaining a T-P-R and B/P within 15 minutes of completion of transfusion."</p> <p>3. Community Hospitals of Indiana, Inc Corporate Nursing Policy and Procedure "Blood Component Administration", NPP#: I-14B1, Effective: 6/17/10 included, on Page 3 "14. During the transfusion of...or upon its completion, if the patient experiences a 2 degree F increase or more in temperature...the transfusion is to be stopped. Call the Blood Bank immediately...and notify physician."</p> <p>4. A#1, Quality Resources Site Manager, was present during the review of blood transfusion records and confirmed the findings.</p>			
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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 document review, the hospital failed to ensure the monthly inspection of 1 area where drugs are stored.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of hospital policy PPP. Fistk002, entitled Medication Storage Area Inspections (aka Unit Inspections), indicated all medication areas are to be inspected at least every 90 days. 2. The period every 90 days is not in accordance with State hospital rules. 3. On 9-19-11 at 2:00 pm, hospital staff was requested to provide documentation of medication inspection reports in the Interventional Radiology (IR) area for the months of March, April and May of year 2011. 4. Hospital staff provided two documents 	S1020	<p>Corrective Action based on ISDOH Citation: North Pharmacy Director will update the network policy to specify drug storage area inspection and implement new inspection schedule by December 1, 2011.</p> <p>Ongoing Monitoring and Evaluation: Monitoring will consist of assigning inspections to staff and review by Pharmacy Director monthly for completion each month. Findings will be corrected immediately and follow up will be done with involved staff, if applicable. Responsible Owner: Director CH-North Pharmacy</p>	10/21/2011	

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	<p>entitled PHARMACY INSPECTION REPORT, INSPECTION AREA: IR, DATE/TIME 1/10/11 and PHARMACY INSPECTION REPORT, INSPECTION AREA: IR, DATE/TIME 4/3/11. Each report indicated there had been pharmacy inspections reviewed by the Pharmacist/Designee.</p> <p>5. No other requested documentation was provided prior to exit.</p>				

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S1024	<p>410 IAC 15-1.5-7 (d)(2)(C)</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>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure multi-dose vials were dated after opening to prevent outdated use on a medical/surgical unit and in the obstetrical (OB) department.</p> <p>Findings included:</p> <p>1. The facility policy titled "Use of Injectable Multiple and Single Dose Containers", last reviewed 12/10, stated on page 1, "...4. For those medications without a pharmacy label, the caregiver or staff person who initially punctures a vial is responsible for writing the expiration date on the vial 28 days from the initial puncture. In some instances, this may be facilitated through the use of a sticker affixed to the vial."</p>	S1024	<p>Corrective Action based on ISDOH Citation: North Pharmacy Director will coordinate education of hospital staff on importance of complying with existing Network policy on dating of multi-dose vials by December 1, 2011.</p> <p>Ongoing Monitoring and Evaluation: North Pharmacy Director or designee will monitor the areas noted in the inspection report (Maternity Services and Med/Surg) on a periodic basis starting in December 2011. North Pharmacy Director will report non-compliance with policy to appropriate manager/director for individual follow-up via the Network's disciplinary action plan. Responsible Owner: Pharmacy Director, CH-North</p>	10/21/2011
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	<p>2. During the tour of the med/surg unit at 11:45 AM on 09/19/11 and accompanied by staff members N1, N3, and N9, a vial of Tubersol was observed open, but not dated, in the medication refrigerator.</p> <p>3. During the tour of the OB unit at 1:45 PM on 09/19/11 and accompanied by staff members N1, N3, and N11, a 50 milliliter vial of sodium bicarbonate was observed open and lying on an open tray of medications in a drawer of an emergency cart. The vial had 09/12 and 0830 written on it.</p> <p>4. During the tour of the OB medication room at 2:15 PM on 09/19/11 and accompanied by staff members N1, N3, and N11, a vial of Labetalol was observed open, but not dated, in a small bin for room 4224.</p> <p>5. At 2:00 PM on 09/19/11, staff member N10 indicated the vial of sodium bicarbonate should have been discarded the same day it was opened. He/she also indicated the whole tray of emergency medications should have been restocked and replaced after it was opened.</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 document review and observation, the facility did not follow its compressed gas safety/storage policy and created conditions which resulted in a hazard to patients, public or employees in 3 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a hospital policy entitled Compressed Gas Safety, Storage indicated <u>cylinders must be stored in an upright position and secured by chain or other appropriate means</u>. This applies to full as well as empty cylinders. On 9-19-11 at 11:05 am in the presence of employees #A1 and #A8, it was observed in the chemical storage area of the Receiving Dock, there was 1 fire extinguisher on the floor unsecured by chain or other appropriate means. On 9-19-11 at 11:10 am in the 	S1118	<p>Corrective Action based on ISDOH Citation: The empty fire extinguisher tank was removed from the facility on 9/21/11. The small SCBA air cylinders found in the gas storage room have been secured as of 9/21/11. The fire extinguisher found in the C. Boiler room was re-located to storage location on 9/21/11. The unsecured tank, once identified, was immediately removed. Unsecured fire extinguishers were immediately secured.</p> <p>Ongoing Monitoring and Evaluation: Scheduled environmental rounds will include focus on any unsecured tanks or fire extinguishers. Any unsecured tanks will be secured upon locating and immediate follow up conducted with involved individual at the time, if indicated.</p> <p>Responsible Owner: Director Facilities CH-North</p>	09/23/2011	

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	<p>presence of employees #A1 and #A8, it was observed in the Medical Gas Room, there were 2 small air tanks on the floor unsecured by chain or other appropriate means.</p> <p>4. On 9-19-11 at 11:30 am in the presence of employees #A1 and #A8, it was observed in the Boiler Room, there was 1 fire extinguisher on the floor unsecured by chain or other appropriate means.</p>			
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S1164	<p>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 4 pieces of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 9-19-11 at 10:30 am, employee #A1 was requested to provide documentation of PM on a floor scrubber. On 9-22-11 at 11:10 am upon interview, employee #A8 indicated there was no documentation of PM on the floor scrubber and none was provided prior to exit. On 9-21-11 at 10:05 am, hospital staff was requested to provide PM documentation of a hoist, #50250, a pulley system (cable column) and wooden stair step, all located in the Carmel Rehab/Sports Medicine offsite. No 			S1164	<p>Corrective Action based on ISDOH Citation: The floor scrubber (and all environmental services equipment) has been inspected, inventoried and entered into the CHN Maintenance Asset Management system by CH-North Facilities Department. The Clinical Engineering Department of Community Hospital North dispatched a technician was on the afternoon of 9/21/11 inspect the items, add them to the inventory, and assign them to an appropriate schedule for periodic inspections.</p> <p>Ongoing Monitoring and Evaluation: Both of these pieces of equipment have been checked and are in the database to ensure that they are re-checked per the established schedule.</p> <p>Responsible Persons: Director, Facilities CH-North & Director Network Clinical Engineering.</p>		09/23/2011

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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 and interview, the hospital failed to properly discharge defibrillators in accordance with manufacturer's recommendations in 6 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a letter dated December 28, 2005 to the hospital from a Senior Technical Support Representative of the manufacturer of the Zoll defibrillator used in the hospital, indicated the Daily Shift Check Checklist included in your operator's manual is outlined in a manner that indicates a shift check is performed 3 times a day. This is assuming that a facility operates on a schedule of three, eight hour shifts. Hospital staff indicated there were three shifts in some areas of the hospital. Review of a document entitled Zoll ACLS & BLS Units Crash Cart Signature Log, indicated for the location of 	S1168	<p>See Attachment A for IDR explanation. We have documentation from the manufacturer that gives approval for daily checks. We respectfully request removal of this citation. Thank you.*****</p> <p>Addendum 1/30/12: IDR request denied.</p> <p>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.</p> <p>Subsequently, the organization will evaluate options to replace</p>	10/21/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>Radiology for the month of August, 2011, there were Daily Monitor Defib Checks once a day, for all 31 days.</p> <p>4. On 9/19/11 at 11:00 AM, review of the defibrillator checks in the Med./Renal/Oncology area indicated there were only daily checks.</p> <p>5. On 9/19/11 at 11:45 AM, review of the defibrillator checks in the G Tower 2 area indicated there were only daily checks.</p> <p>6. On 9/20/11 at 9:30 AM, review of the defibrillator checks in the 1 NE-Intractable Pain area indicated there were only daily checks.</p> <p>7. On 9/20/11 at 10:05 AM, review of the defibrillator checks in the Seasons (BSC) area indicated there were only daily checks.</p> <p>8. On 9/20/11 at 2:40 PM, review of the defibrillator checks in the Daybeds unit indicated there were only daily checks.</p>		<p>the M Series defibs with the new R series units, for which the manufacturer does require checking them once per shift.</p> <p>See attached policy revised Jan 2012.</p>		