

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/02/2013
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NAME OF PROVIDER OR SUPPLIER  SELECT SPECIALTY HOSPITAL- INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8060 KNUE ROAD INDIANAPOLIS, IN 46250
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 008900</p> <p>Survey Date: 9-30/10-2-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 10/15/13</p>	S000000		

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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S000270	<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 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 2012 indicated they did not include review of reports for the contracted Nursing service.</li> <li>2. In interview, on 10-2-13 at 10:30 am, employee #A1 confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S000270	<p>S 270 410 IAC 15-1.4-1 Governing BoardThe CEO added contracted Nursing Services to the contract service matrix on October 17, 2013. Quality indicators that were incorporated into the contracts for these services are: completion of SERC education prior to their first shift and a performance evaluation completed by the House Supervisor on their first shift. The CEO will monitor the quality indicators and will report quarterly to the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board.Responsible Person: Cheryl Gentry, Chief Executive Officer</p>	10/17/2013	

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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR) in accordance with hospital policy for 1 of 1 allied health staff credential file reviewed.</p> <p>Findings:</p> <p>1. Review of 1 allied health staff credential file indicated file AH#1 did not have any documentation of CPR competency.</p> <p>4. In interview, on 10-2-13 at 1:20 pm, employee #A3 confirmed the above and</p>	S000318	S 318410 IAC 15-1.4-1 Governing Board (IDR) Health Information Management-Credentialing mailed a letter on February 11, 2014 to the Allied Health Practitioners. The letter informed them of the need to provide proof of CPR certification in accordance with hospital policy governing CPR competence. Evidence of certification will need to be submitted within 30 days and received no later than March 11, 2014. CPR verification will be kept in the practitioner's credential file. HIM will monitor the CPR status and report findings to the Chief Executive Officer. Credentialing requirements, including CPR	02/11/2014			

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S000330	<p>indicated she/he could not provide documentation of a CPR policy for credentialed practitioners. No further documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 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: (6) Require that the chief executive officer develops policies and programs for the following: (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 facility failed to follow their policy for pre-employment physicals for 14 of 18 employee personnel files reviewed.</p> <p>Findings:</p>	S000330	<p>status, will be reported quarterly to the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Responsible Person: Cheryl Gentry, CEO</p> <p>S 330410 IAC 15-1.4-1 Governing Board Effective October 1, 2013, the process for reviewing the employee health screening form was changed to include the reviewer's signature below the employee's signature. The corporate employee health screening form was revised on</p>	10/18/2013	

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	<p>1. Review of facility Policy IC X-2, entitled Employee Screening: New Hire and Ongoing, revised July, 2013, indicated all applicant staff health assessments and screens are performed by the Employee Health Nurse. It further indicated The DQM [Designated Quality Manager] or designee reviews completed medical history questionnaire.</p> <p>2. Review of 18 employee personnel files indicated files P1, P2, P3, P4, P5, P7, P31, P32, P33, P34, P35, P36, P37 and P38 did not have documentation of applicant staff health assessments and screens having been performed by the Employee Health Nurse nor a review of the medical history questionnaire having been completed by the DQM or designee.</p> <p>3. In interview, on 10-1-13 at 11:15 am, employee #A1 confirmed the above and no further documentation was presented prior to exit.</p>		<p>October 18, 2013 to include a signature line for the Director of Quality Management or designee. Employee health data will be reported on a quarterly basis to the Organizational Improvement Committee, Medical Executive Committee, and Governing Board. Responsible Person: Lisa Ruggles, Director of Quality Management</p>		

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S000554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 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, the hospital created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors.</p> <p>Findings:</p> <p>1. On 9-30-13 at 11:30 am, in the presence of employee #A4, it was observed in a Housekeeping storage area, there were 29 packages of handtowels stored on an open shelf. The ends of the packages were not covered by any wrap and the packages were not covered or enclosed while on the shelf. This posed the potential for cross-contamination of the items used on patients, employees and visitors.</p>	S000554	<p>S 554410 IAC 15-1.5-2 Infection ControlThe Director of Plant Operations covered the packages of hand towels with protective plastic sheeting on September 30, 2013 at the time of the survey. The Director of Plant Operations revised the storage process on October 17, 2013 and the boxes of hand towels were relocated to the Materials Management Supply room. Responsible Person: Paul Wildnauer, Director of Plant Operations</p>	10/17/2013			

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S000952	<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 policy/procedure review, transfusion record review, and staff interview, the facility to follow approved medical staff policies and procedures for the administration of three of five blood transfusions reviewed.</p> <p>Findings include: 1. On 10/01/13 at 9:00 a.m. two blood transfusion administration procedures were reviewed with SP#2: a. Blood /Blood Components Administration, Number: B04-N last revised 07/01/12 which stated: "6. Take patient's BP (blood pressure) and TPR (temperature, pulse, respirations) for baseline and record on Blood Transfusion Record. 8. vital signs (including temp) should be recorded prior to starting," b. Blood Component Administration, BB.rehab.1.0, Effective 12/01/2012,</p>	S000952	S 952410 IAC15-1.5-6 Nursing ServiceThe Chief Nursing Officer re-educated the House Supervisors and Charge Nurses on the Blood Administration policy on October 17, 2013. The Blood Administration policy was approved by the Governing Board on April 4, 2013. The Chief Nursing Officer instructed the House Supervisors and Charge Nurses to review the Blood Administration with the clinical staff during day and night shift huddles. Education during shift huddles was completed by October 20, 2013. Audits on blood transfusions will be performed as follows: 100% of blood transfusions for 2 weeks, 50% of blood transfusion for 2 weeks, then randomly on an ongoing basis. The Director of Quality Management or designee will perform the audits. Employees that are identified as being non-compliant will be addressed through the	10/17/2013			

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S001164	<p>document Version: 0.1 which stated: "8.0 vital signs (including temp) should be recorded prior to starting, ....."</p> <p>2. On 10/01/13 between 9:00 a.m. and 11:00 a.m. review of five transfusion records indicated:</p> <p>a. Transfusion #1 had previtals taken at the same time as the start of the transfusion, 1725 for both.</p> <p>b. Transfusion #2 had the previtals taken at 0144, two minutes after the transfusion started at 0142.</p> <p>c. Transfusion #3 had the previtals taken at 0017, five minutes after the transfusion started at 0011.</p> <p>3. In interview on 10/01/13 at 10:00 a.m. SP (staff person) #2 acknowledged the policy/procedures were not being followed.</p> <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</p>	S001164	disciplinary process. Audit data will be reported monthly to the QAPI Committee and quarterly to the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Responsible Person: Melissa McLeish, Chief Nursing Officer			10/18/2013	

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	<p>interview, the hospital failed to document annual preventive maintenance (PM) for 5 pieces of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 9-30-13 at 9:45 am, employee #A4 was requested to provide documentation of the PM for a floor scrubber.</li> <li>In interview, on 10-2-13 at 10:00 am, employee #A4 indicated there was no documentation of PM for the floor scrubber and no further documentation was provided prior to exit.</li> <li>On 9-30-13 at 10:45 am, employee #A4 was requested to provide documentation of the PM for the parallel bars, stair step, and an exam table located in Physical Therapy treatment area.</li> <li>On 9-30-13 at 10:50 am, employee #A4 was requested to provide documentation of the PM for a bariatric wheelchair located in the Physical Therapy storage area.</li> <li>In interview, on 10-1-13 at 4:10 pm, employee #A4 indicated there was no documentation of PM for the bariatric</li> </ol>		<p>PlantThe Director of Plant Operations contacted UHS Biomedical Company to perform the preventive maintenance on the parallel bars, exam table, and stair steps. Preventive maintenance was completed on October 1, 2013 and no deficiencies were identified. UHS added the parallel bars, exam table, and the stair steps to their preventive maintenance schedule on October 1, 2013. The Director of Plant Operations performed the preventive maintenance on the floor scrubber on October 7, 2013 and no deficiency was identified. The Director of Plant Operations entered a work order into the Site FM Work Order system on October 1, 2013. The work order added the floor scrubber to the preventive maintenance schedule. Preventive maintenance was performed on the bariatric wheelchair on October 18, 2013 by the Director of Plant Operations and no deficiency was identified. The Director of Plant Operations entered a work order into the Site FM Work Order system on October 18, 2013 which has added the bariatric wheelchair to the preventive maintenance schedule. The Director of Plant Operations will report the preventive maintenance data quarterly to the Organizational Improvement Committee, Medical Executive Committee, and the Governing Board. Responsible</p>		

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S001168	<p>wheelchair, parallel bars, stair step, and an exam table, and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 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 and interview, the hospital failed to properly keep a discharge log for 1 of 1 defibrillator, according to manufacturer recommendations.</p> <p>Findings:</p> <p>1. Review of manufacturer recommendations for the facility's HeartStart MRx defibrillator, indicated in order to ensure defibrillators are ready when needed, the American Heart Association (AHA) recommends that users complete a checklist, often referred to as a shift check, at the beginning of each change in personnel.</p>	S001168	<p>Person: Paul Wildnauer, Director of Plant Operations</p> <p>S 1168410 IAC 15-1.5-8 Physical PlantThe Chief Nursing Officer revised the process and provided education to the House Supervisors and Charge Nurses on October 21, 2013. The process was revised to perform a defibrillator check on each shift. The defibrillator check will be documented on the emergency crash cart form currently in use. The Chief Nursing Officer or designee will check the form each shift for 2 weeks to ensure compliance.Responsible Person: Melissa McLeish, Chief Nursing Officer</p>	10/21/2013	

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S001184	<p>Philips Healthcare [(the manufacturer)]supports the AHA checklist recommendations.</p> <p>2. In interview, on 10-2-13 at 10:45 am, employee #A3 indicated the hospital had 2 nursing shifts each day.</p> <p>3. Review of a facility document entitled Emergency Equipment/Code Cart Check List, for the defibrillator located on the FIRST FLOOR, for the month of September, 2013, indicated completion of the Check List one (1) time each day. Thus, the hospital did not follow the manufacturer's recommendation.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(2)</p> <p>(f) The safety management program shall include, but not be limited to, the following:</p> <p>(2) A safety committee appointed by the chief executive officer that includes representatives from administration, patient services, and support services.</p> <p>Based on document review and</p>	S001184	S 1184410 IAC 15-1.5-8 Physical	10/18/2013			

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	<p>interview, the facility failed to document the Safety Committee included representatives from administration and patient services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 10-1-13, initial review of the Safety Committee minutes for year 2013, dated 1-23, 1-18, 3-28, 4-25, 5-25, 6-26, and 7-22, indicated they did not include representatives from administration and patient services.</li> <li>2. On 10-2-13, re-review of the above minutes indicated the other required members were hand-written as having attended.</li> <li>3. In interview, on 10-2-13 at 9:40 am, employee #A4 indicated the names had been written in by hand, after the initial review and prior to the re-review.</li> <li>4. No other documentation was provided prior to exit.</li> </ol>		<p>PlantThe Director of Plant Operations revised the Safety Committee meeting agenda on October 1, 2013. The section titled invitees was changed to attendees in order to indicate specific individuals who were in attendance. A separate signature sheet was also created on October 18, 2013. The signature sheet will function as confirmation of attendance. Responsible Person: Paul Wildnauer, Director of Plant operations</p>		