

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  10/01/2014
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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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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005109</p> <p>Survey Date: 9-29/10-1-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: cloughlin 10/28/14</p>	S000000		
S000284	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (b)(3)</p> <p>(b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules and that</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 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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	<p>the bylaws and rules are reviewed and approved at least triennially. Governing board approval of medical staff bylaws and rules shall not be unreasonably withheld.</p> <p>Based on interview, the governing board failed to ensure the medical staff had triennially approved medical staff rules.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 9-29-14 at 11:00 am, employee #A2, Quality Resources Site Leader, was requested to provided documentation the governing board had approved of the medical staff rules within the last three years.</li> <li>In interview, on 10-1-14 at 3:10 pm, employee #A2 indicated there was no documentation that the governing board had approved of the medical staff rules within the last three years.</li> </ol>	S000284	<p><b>Issue Identified:</b> S284: Medical staff rules were not approved by the Governing Board as per policy of triennial approval.</p> <p>-</p> <p><b>Short Term Remedy:</b> On 11/11/14, 20 Medical Staff policies were presented to the Medical Executive committee for review and approval, to be sent to the Community Health Network Governing Board for the 1/21/15 meeting. (The Governing Board does not meet during the month of December.) 16 polices were passed for Governing Board submission. Further review will be conducted at the 12/9/14 Medical Executive meeting of 4 polices that has received major changes. At this time, all polices will have been reviewed, passed, and submitted for approval by the Governing Board. (See attached list of policies)</p> <p><b>Date Started:</b> 10/5/2014</p> <p><b>Date to be Completed:</b></p>	01/21/2015

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			<p>1/21/2015</p> <p>-</p> <ul style="list-style-type: none"> <li>· <b><u>Long Term Remedy:</u></b> All policies will be reviewed at the same time to ensure that there are no policies that get missed in the triennial review period.</li> <li>· <b><u>Date Started:</u></b> 10/5/14</li> <li>· <b><u>Date to be Completed:</u></b> 1/21/15</li> <li>· <b><u>Plan to prevent future recurrence:</u></b> New leadership is in place in the Medical Staff department, with responsibilities assigned for monitoring the review period for policies.</li> <li>· <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position)  The Director of Medical Staff Services will be responsible for ensuring that triennial reviews of medical staff policies are being</li> </ul>	

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S000406	<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>completed.</p> <p><b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)</p> <p>- The first step for completion of this corrective action is review by the Medical Executive Committee. This will be completed in totality by 12/9/14. The Governing Board will not meet again until 1/21/15. At this meeting, all policies will be presented after receiving approval from the Medical Executive Committee at the 12/9/14 meeting.</p>	

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	<p>Based on document review and interview, the hospital failed to include a standard for 1 service (tissue transplant) provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the facility's QAPI program indicated it did not include a standard for the contracted services of tissue transplant.</li> <li>In interview, on 10-1-14 at 12:30 pm, employee #A7, Clinical Director Surgery Services, confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S000406	<p><b>Issue Identified:</b> S406: Lack of Quality Indicator for tissue transplant services</p> <p>-</p> <p>-</p> <p><b>Short Term Remedy:</b> All data has been monitored, it was just not recorded in the Quality Indicator report. An indicator was built and included on the report (see attached).</p> <p><b>Date Started:</b> 10/13/14</p> <p><b>Date to be Completed:</b> 11/12/14</p> <p>-</p> <p><b>Long Term Remedy:</b> Quality Indicator for transplant services will be added to 2014 report, and also included in the 2015 and beyond reports.</p> <p>-</p> <p><b>Date Started:</b> 10/27/14</p> <p><b>Date to be Completed:</b> 11/12/14</p>	11/12/2014	

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S000416	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(3)</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</p>		<p>-</p> <ul style="list-style-type: none"> <li><b>Plan to prevent future recurrence:</b> Surgical Services Director will continue to track and monitor all tissue transplant services provided at Community Hospital South.</li> <li><b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position)  Director of Surgical Services</li> <li><b>What date will deficiency be corrected?</b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)  11/12/14</li> </ul>	

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	<p>program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(3) All medical and surgical services performed in the hospital with regard to appropriateness of diagnosis and treatments related to a standard of care and anticipated or expected outcomes.</p> <p>Based on document review and interview, the hospital failed to review medical services performed in the hospital with regard to appropriateness of diagnosis and treatments related to a standard of care and anticipated or expected outcomes as part of its quality assessment and improvement (QA&amp;I) program for 4 (MD#3, MD#5, MD#6, MD#7) of 5 credential files of medical staff members.</p> <p>Findings:</p> <p>1. Review of 5 credential files of medical staff members, indicated files MD#3, a teleradiologist, MD#5, an orthopedic surgeon, MD#6, a telepsychiatrist, and MD#7, a reconstructive surgeon, had no documentation of medical services performed in the hospital with regard to appropriateness of diagnosis and treatments related to a standard of care and anticipated or expected outcomes, as</p>	S000416	<p><b>Issue Identified:</b> S: 416: Missing Ongoing Professional Practice Evaluation for Physicians</p> <p>-</p> <p>-</p> <p><b>Short Term Remedy:</b> The OPPE process is currently in place. Every MD has had a review completed on them and their practice, but it was discovered that some of the data was missing at the time of the run of the report. The Knowledge Management Department was currently in the process of correcting this issue with the Epic EMR system, and had not had it completed at the time the ISDOH survey was conducted. The addition of the process has now been completed, and all reports have been run and reviewed by the respective department leaders according to the OPPE policy.</p>	11/03/2014

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	<p>part of its QA&amp;I program.</p> <p>2. In interview, on 9-30-14 at 10:50 am, employee #A2, Quality Resources Site Leader, indicated the facility attempted to use an automated system as part of the process of performance review for the above-stated medical staff members. The employee also indicated the process could not be completed because the system was not operating properly. The employee also indicated the facility did not use the prior system to review the performances once it was determined the automated system was not working properly. No other documentation was provided prior to exit.</p>		<ul style="list-style-type: none"> <li>· <b><u>Date Started:</u></b> 1/6/14</li> <li>· <b><u>Date to be Completed:</u></b> 11/3/14</li> <li>· -</li> <li>· <b><u>Long Term Remedy:</u></b> Per Community Health Network, all OPPE reports are completed every 6 months and more often if there is a quality of care issue identified. (See attached policy).</li> <li>· -</li> <li>· -</li> <li>· <b><u>Date Started:</u></b> 1/6/14</li> <li>· <b><u>Date to be Completed:</u></b> 11/3/14</li> <li>· -</li> <li>· <b><u>Plan to prevent future recurrence:</u></b> Data is loaded from the Community Health Network system, to the Crimson system, on the 15th of each month. If there are any missing files during this load, the representative from Crimson will notify the Knowledge Management Department Representative, and the files will be re-submitted.</li> </ul>	

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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 review of policies and procedures, observation and staff interviews, the hospital failed to provide a safe and healthful environment in two (2) instances (obstetrics unit, Cardiac Catheterization Lab) increasing risk to patients and visitors.</p>	S000554	<p><b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position)</p> <p>Quality Resources Site Leader/Knowledge Management Manager</p> <p><b>What date will deficiency be corrected?</b> (Must provide specific date- Month- Day- Year.</p> <p>Maximum correction time allowed is 30 days from the date of survey.)</p> <p>11/3/14</p> <p><b>Issue Identified:</b> S554: Multiple medical units had debris in drawers, dust on light fixture in cath lab</p>	11/11/2014

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	<p>Findings include:</p> <ol style="list-style-type: none"> <li>Hospital Patient Food Services Policy, Volume IV, #13, which addresses cleaning pantries, last reviewed 3/11/2011, does not address cleaning drawers.</li> <li>Policy CCL:#005 Titled "Cleaning and Sanitation of Cath Lab Procedure Rooms and Support Areas" Performed by: Cath Lab Staff, Environmental Services Staff. Procedure: A. Beginning of Day: Prior to the first scheduled procedure of the day, the following items will be damp dusted with hospital disinfectant. <ol style="list-style-type: none"> <li>X-ray equipment</li> <li>Surgical lights</li> <li>Injector machine</li> </ol> </li> <li>At 1:30 p.m. on 9/29/2014, during a tour of the obstetrics unit, it was noted that in pantry one, several drawers and cabinets contained small amounts of dried light brown substance, and spilled coffee grounds. Pantry two, drawers also contained dried brownish substance and coffee grounds, and what appeared to be dried peanut butter.</li> <li>At 2:00 p.m. on 9/29/2014, the surgical unit's (5S) pantries one and two</li> </ol>		<ul style="list-style-type: none"> <li><b>Short Term Remedy:</b> Drawers were all wiped down on medical units; light fixtures were cleaned in cath lab.</li> <li><b>Date Started:</b> 10/3/14</li> <li><b>Date to be Completed:</b> 10/3/14</li> <li><b>Long Term Remedy:</b> Policy MSF13 was revised to include the responsibility of the Nutrition and Food Services employees to clean the drawers if soiled, before restocking with nourishments. Responsibilities were readdressed with all staff that performs this function. (See attached policy with additional information highlighted). Drawer dividers are being ordered to keep the drawers orderly.  Cath lab currently has a policy (see attached) that addresses daily cleaning functions. This</li> </ul>	
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	<p>drawers contained brown dried liquid and spilled coffee grounds. In addition, pantry one's left drawers had spilled creamer and what appeared to be dried bread crumbs.</p> <p>5. At 2:30 p.m. on 9/29/2014, during tour of the hemoc (hemo-oncology) unit (4th floor), it was noted that pantry drawers also contained small amounts of dried, light brownish liquid and loose coffee grounds.</p> <p>6. Staff member #2 agreed with the findings.</p> <p>7. At 1:00 p.m., on tour of the Cardiac Catheterization Lab, in the presence of Staff members #2 and #8, a layer of dust was noted on the light fixture over the patient procedure table and on the C-arm of room one. The first case of the day had just finished in that room.</p> <p>8. Findings indicated that hospital policy CCL#005 had not been followed that morning.</p>		<p>task had not been carried out the morning of the survey. Policy CCL005 was reviewed with all staff with the expectation that these tasks will be completed on a daily basis.</p> <p>-</p> <ul style="list-style-type: none"> <li>· <b>Date Started:</b> 10/3/14</li> <li>· <b>Date to be Completed:</b> 10/7/14-Cath lab 11/11/14-Nutrition and Food Services</li> <li>-</li> <li>· <b>Plan to prevent future recurrence:</b> Cath lab has added the cleaning to their daily task list for the department. Nutrition and Food Services management will do random checks of drawers, along with the Nursing Leadership for each department.</li> <li>· <b>Who is responsible for numbers 1 &amp; 2 above?</b> (Not by name, but by position)  Director of Food and Nutrition Services, Director of Cath Lab</li> </ul>	

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S000838	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (b)(1)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:</p> <p>(1) be approved by the governing board; Based on interview, the medical staff failed to review the medical staff rules at least triennially.</p> <p>Findings:</p> <p>1. On 9-29-14 at 11:00 am, employee #A2, Quality Resources Site Leader, was requested to provided documentation the medical staff had approved of the medical staff rules within the last three years.</p> <p>2. In interview, on 10-1-14 at 3:10 pm, employee #A2 indicated there was no documentation that the medical staff had approved of the medical staff rules within</p>	S000838	<p><b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)</p> <p>10/7/14-Cath Lab 11/11/14-Food and Nutrition</p> <p><b><u>Issue Identified:</u></b> S838: Medical staff rules were not approved by the Medical Executive Committee as per policy of triennial approval.</p> <p><b><u>Short Term Remedy:</u></b> On 11/11/14, 20 Medical Staff policies were presented to the Medical Executive committee for review and approval. 16 polices were passed for Governing Board submission. Further review will be conducted at the 12/9/14 Medical Executive meeting of 4 polices that</p>	12/09/2014

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	the last three years.		<p>has received major changes.</p> <p>-</p> <ul style="list-style-type: none"> <li>· <b>Date Started:</b> 10/5/2014</li> <li>· <b>Date to be Completed:</b> 12/9/14</li> </ul> <p>-</p> <ul style="list-style-type: none"> <li>· <b>Long Term Remedy:</b> All policies will be reviewed at the same time to ensure that there are no policies that get missed in the triennial review period.</li> </ul> <p>-</p> <ul style="list-style-type: none"> <li>· <b>Date Started:</b> 10/5/14</li> <li>· <b>Date to be Completed:</b> 12/9/14</li> </ul> <p>-</p> <ul style="list-style-type: none"> <li>· <b>Plan to prevent future recurrence:</b> New leadership is in place in the Medical Staff department, with responsibilities assigned for monitoring the review period for policies.</li> </ul>	

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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, and transfusion record review, the facility failed to follow approved medical staff procedures for 1 of 7 transfusions</p>	S000952	<p>· <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position)</p> <p>The Director of Medical Staff Services will be responsible for ensuring that triennial reviews of medical staff policies are being completed.</p> <p>· <b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)</p> <p>12/9/14</p> <p>· <b><u>Issue Identified:</u></b> S952: Blood administration time was documented as the same time</p>	11/12/2014

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	<p>reviewed.</p> <p>Findings included:</p> <p>1. On 9/29/14 review of a policy/procedure titled: "CORPORATE NURSING POLICY AND PROCEDURE NPP3#: I-14B1 EFFECTIVE: 8/8/13" indicated: " 15. Nursing will monitor the patient ....."</p> <p>a. "b. By obtaining and recording the temperature, pulse, and respirations (T-P-R) and blood pressure (BP) before the start time of the transfusion and</p> <p>b. the second set of vital signs between the first 10 and 20 minutes of the infusion."</p> <p>c. "d. By obtaining T-P-R and B/P within 15 minutes of completion of transfusion."</p> <p>2. During transfusion record review the surveyor noted T (transfusion) #3 indicated the transfusion was started at the same time the Pre vitals were taken, therefore the pre set of vitals were not taken before the transfusion started, to determine if the recipient was able to safely be transfused.</p>		<p>as the blood administration time.</p> <p>-</p> <p>· <b>Short Term Remedy:</b> Per our blood administration policy, vital signs are to be done in the 15 minute window pre-transfusion. Communication was sent out to all Nursing Leadership at CHS to re-iterate with their staff this requirement, as was addressed in the blood transfusion learning module.</p> <p>· <b>Date Started:</b> 11/11/14</p> <p>· <b>Date to be Completed:</b> 11/11/14</p> <p>-</p> <p>· <b>Long Term Remedy:</b> In order to hardwire and improve our processes, the Blood Management Officer will begin auditing and monitoring all transfusion forms for the South Campus. Upon review if she finds opportunities she will be in contact with Quality/Risk Management and the Nursing Leader of that department to discuss next steps and interventions for improvement.</p>	

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S001166	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)  (d) The equipment requirements are as follows:		<ul style="list-style-type: none"> <li>· <b><u>Date Started:</u></b> 11/12/14</li> <li>· <b><u>Date to be Completed:</u></b> 2/12/14</li> <li>· <b><u>Plan to prevent future recurrence:</u></b> Random audits will be conducted by both Nursing Leadership and Blood Management Officer to ensure that compliance is maintained after the 3 month audit period.</li> <li>· <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position)  Blood Management Officer</li> <li>· <b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)  11/12/14</li> </ul>	

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	<p>(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>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks. Based on document review and interview, the hospital failed to keep current leakage checks on 3 pieces of equipment.</p> <p>Findings:</p> <p>1. Review of preventive maintenance (PM) documents for a Birthing/Newborn bed, an Adult Med/Surg bed, and a special (I.C.U) bed, indicated it did not document current leakage checks.</p> <p>2. In interview, on 9-30-14 at 1:50 pm, employee #A5, Director of Facilities, confirmed the above and no further documentation was provided prior to exit.</p>	S001166	<p><b>Issue Identified:</b> S1166: Current leakage checks on multiple inpatient beds were not documented.</p> <p><b>Short Term Remedy:</b> All beds are not being checked for leakage and recording of the grounding is being completed.</p> <p><b>Date Started:</b> 10/7/14</p> <p><b>Date to be Completed:</b> 10/7/14</p> <p><b>Long Term Remedy:</b> A new form was developed to reflect that the leakage and grounding is being completed. This was being</p>	10/07/2014

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S001168	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)		<p>done on a monthly basis, but not recorded per the ISDOH surveyor's standards. (See attached new form)</p> <p>-</p> <ul style="list-style-type: none"> <li>· <b><u>Date Started:</u></b> 10/7/14</li> <li>· <b><u>Date to be Completed:</u></b> 10/7/14</li> <li>-</li> <li>· <b><u>Plan to prevent future recurrence:</u></b> Form will be completed and reviewed each month.</li> <li>· <b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position)  Director of Facilities</li> <li>· <b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)  10/7/14</li> </ul>	

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	<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 follow some of the manufacturer's recommendation for daily testing of 1 of 1 defibrillator.</p> <p>Findings:</p> <p>1. Review of the Zoll manufacturer's manual for a hospital defibrillator indicated recommended checks and procedures to be performed at the start of each shift. The OPERATOR'S SHIFT CHECKLIST indicated the following:</p> <p><b>Paddles</b> Paddles clean, not pitted Release from housing easily</p> <p><b>Inspect cables for cracks, broken wires, connector</b> A. ECG electrode cable, connector B. Defibrillator paddle cables C. Multi-function cable, connector</p> <p><b>Batteries</b> A. Fully charged battery in unit B. Fully charged spare battery available</p>	S001168	<p><b>Issue Identified:</b> S1168: Hospital failed to follow some of the manufacturer's recommendations for daily testing of defibrillators.</p> <p>-</p> <p>-</p> <p><b>Short Term Remedy:</b> Critical Care Clinical Nurse Specialist for the Community Health Network reviewed the citation in depth, along with the manufacturer's guidelines for submission of changes to the current log for defibrillator checks.</p> <p><b>Date Started:</b> 11/6/14</p> <p><b>Date to be Completed:</b> 11/6/14</p> <p>-</p> <p><b>Long Term Remedy:</b></p>	12/05/2014

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	<p><b>Disposable supplies</b></p> <p>A. Electrode gel or gel patches</p> <p>2. Review of a document entitled ZOLL ACLS &amp; BLS UNITS CRASH CAR SIGNATURE LOG, for the month of September 2014, indicated it did not include the above items to be checked nor was there any reference to the OPERATOR'S SHIFT CHECKLIST.</p> <p>3. Review of hospital policy CORP#: CLN-2005, entitled CARDIOPULMONARY RESUSCITATION, effective 4/18/14, did not include the above items to be checked nor was there any reference to the OPERATOR'S SHIFT CHECKLIST.</p> <p>4. In interview, on 10-1-14 at 2:30 pm, employee #A2, Quality Resources Site Leader, confirmed the ZOLL ACLS &amp; BLS UNITS CRASH CAR SIGNATURE LOG, for the month of September 2014, was used to document testing of the defibrillator. No further documentation was provided prior to exit.</p>		<p>We are a hand's free facility, so there are no paddles to check, as we use pacing pads. On the top of page 2 of the log sheet, it has the instructions as far as checking cables for cracks, etc. Batteries are changed every 2 years by biomed. Additional detail per suggested inclusions by the ISDOH will be included and updated to the log. This has been reviewed and will go to the forms committee for updating to the Eform printing system for Community Health Network.</p> <p>· <b><u>Date Started:</u></b> 11/6/14</p> <p>· <b><u>Date to be Completed:</u></b> 12/5/14</p> <p>·</p> <p>· <b><u>Plan to prevent future recurrence:</u></b> All items suggested by the manufacturer/ISDOH will be included to the new log, and re-evaluation will be done if the monitors are replaced and have new manufacturer's guidelines.</p>	

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			<p><b><u>Who is responsible for numbers 1 &amp; 2 above?</u></b> (Not by name, but by position)</p> <p>Clinical Nurse Specialist for Critical Care</p> <p><b><u>What date will deficiency be corrected?</u></b> (Must provide specific date- Month- Day- Year. Maximum correction time allowed is 30 days from the date of survey.)</p> <p>12/5/14</p>		