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	150169	A. BUILDING 00 B. WING	04/16/2014

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COMMUNITY HOSPITAL NORTH	7150 CLEARVISTA DR INDIANAPOLIS, IN 46256

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S000000	This visit was for a standard licensure survey. Facility Number: 011437 Survey Dates: 4-14/16-14 Surveyors: Jack I. Cohen, MHA Medical Surveyor Linda Plummer, RN Public Health Nurse Surveyor Steve Poore Medical Surveyor QA: claughlin 04/24/14 Per the IDR Committee meeting on 06-16-14 tags 0270 & 0406 were deleted. John Lee Program Manager Hospitals/ASCs	S000000		
S000308	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	(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: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on document review and interview, the facility failed to ensure the orientation of off site contracted cleaning staff in one off site toured (146th street, Noblesville). Findings: 1. review of the QBM (quality building maintenance) job description for the off site "Building Supervisor" indicated: a. included in their "Duties" was "Trains all new associates to insure their success in both job completion and customer satisfaction. Training is conducted for a minimum period of 2-weeks with each new cleaner." 2. review of the personnel file for the contracted off site housekeeper N12 indicated: a. the hire date was 3/13/14 b. the QBM list of cleaning processes and expectations was signed by a human	S000308	Findings 1,2: Accountable leader: Director of Property ManagementCorrection Date: 5/16/14Correction: reviewed with contract cleaning service (Quality Building Maintenance - QBM). Employee's training/orientation will be documented by the supervisor and the file of offsite employee N12 will be brought up to date. All off site housekeeping employee files will include documentation of orientation and two week training period signed off by their designated supervisor. Finding 3:Accountable leader: CHN Site Leader Infection Prevention Correction Date: Incremental Phase I: 5/16/14, Phase 2: 6/16/14Correction: 1) Ambulatory Care Infection Preventionist has been hired to round and monitor all off site locations annually (incremental phase I date) 2) Rounding on all off site facilities will be completed by 6/16/2014 (incremental phase 2 date)3) Cleaning policies/procedures for he	05/16/2014

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	resources staff member, not the employee's direct supervisor/trainer c. there was no documentation of orientation by the supervisor d. there was no documentation of the two week period of training that is to be conducted by the supervisor as listed in the job description in 1. above 3. interview with staff member #80, the infection preventionist, at 10:30 AM on 4/15/14, indicated: a. the infection control committee is not currently monitoring the off site imaging location contracted cleaning company b. the infection control committee has not approved of the cleaning processes used by QBM ("Clinical Training Procedures"		following contracted EVS companies will be reviewed annually and as needed for any changes in practice and placed on the Infection Prevention Committee agenda to be approved (incremental phase 2 date). • ABM • Quality Building Maintenance • Corporate Cleaning Systems	
S000318	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F) (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: (F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of			

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	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 and current standards of practice for 4 of 7 medical staff credential files reviewed. Findings: 1. Review of a medical staff policy and procedure entitled CARDIOPULMONARY RESUSCITATION (CPR) REQUIREMENTS, last approved by the medical staff and governing board 1-14-13, indicated: It is a requirement that these [Emergency Medicine] physicians either be board certified in Emergency Medicine or have current Advanced Cardiac Life Support (ACLS) certification. Anesthesiologists demonstrate their competency in CPR by sustaining an active practice in their field of specialty and by the very nature of the specialty which undergoes ongoing peer review as per our peer review policies.	S000318	**Responsible Party for follow-up and correction:** Medical Staff Office (MSO) Credentialing Coordinator **System by which the responsible party will monitor:** Reports from the MSO physician database (Cactus) **Frequency of monitoring:** Monthly reports will be generated for compliance **Ongoing Monitoring to be determined:** Monthly Cactus reports will be an ongoing function **ACTION PLAN:** 1. The Cardiopulmonary Resuscitation (CPR) Requirements were approved by MEC on August 20, 2013. 2. The one physician (MD#3 – hospitalist) not meeting the CPR competency requirement will be contacted by May 5, 2014 to assess whether he had completed the ACLS certification. If it has not been completed every effort will be made to complete within 30 business days of May 5, 2014 (June 12, 2014)	05/16/2014

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	At Community Hospitals North, contracted hospitalists, critical care, intensivists and/or pulmonary medicine physicians are required to be certified in BLS [Basic Life Support] and ACLS. A pediatric Hospitalist or Pediatric Intensivist is required to be certified in Pediatric Advanced Life Support (PALS). Competency is demonstrated by maintaining current BLS, ACLS, PALS, ... as well as through ongoing quality review processes. Many of our other physicians ... maintain competence in CPR, but this is not a requirement. 2. Review of the above policy did not indicate what was the hospital policy for those physicians not specified.in that policy, nor what was the definition of current standards of practice. 3. Review of 7 medical staff credential files indicated files MD#3 (hospitalist), MD#4(neurosurgeon), MD#6 (plastic surgeon), and MD#7 (orthopedic surgeon), did not have any documentation of current CPR competency in accordance with current standards of practice and hospital policy. 4. In interview, on 4-14-14 at 2:55 pm,		3. An assessment of all physicians requiring CPR certification will assessed by May 12, 2014 (started on May 5, 2014). 4. Although not cited, if there are any physicians in the identified categories requiring CPR competency that have not completed the appropriate CPR certification, they will be required to complete by August 29, 2014 (also, ongoing). "The policy does state the management and expectations of physicians outside the realm of Emergency Medicine (competent by board certification or ACLS), Operating Rooms (anesthesiologists by sustaining an active practice in their field), Neonatal intensive care unit (neonatologist to be NRP certified) and pediatric ICU (pediatric intensivist to be PALS certified. The critical care, intensivists., hospitalists, and /or pulmonary medicine physicians are required to be certified in BLS and ACLS." **"Many of our other physicians maintain competence in CPR, but it is not a requirement**." This statement means that outside of the practicing physicians noted above, physicians in other specialties/medical departments are not required to be certified for competence in CPR.	

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	employee #A15 did not agree the above physicians did not have any documentation of current CPR competency in accordance with current standards of practice and hospital policy, however, no further documentation was provided prior to exit to support employee #15's disagreement.		Therefore, MD# 4 (neurosurgeon), MD#6 (plastic surgeon) and MD# 7 (orthopedic surgeon) are not required to be CPR certified by policy or standards of care. However, MD#3 (hospitalist) is required to be ACLS certified. The plan above will be instituted.	
S000520	410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1(b)(3) (b) The food and dietetic service shall have the following: (3) Administrative and technical personnel competent in their respective duties. Based on policy and procedure review, observation, and interview, the dietician failed to ensure that dietary personnel were competent in their duties in relation to the cleaning of pantry refrigerators in 3 units toured. Findings: 1. review of the policy and procedure "Meal Service/Feedings #13", from the "Patient Food Services Policies & Procedures Volume IV", with a last date	S000520	Findings: All Accountable leader: Food Services DirectorCorrection Date: 5/9/2014Correction: Education was completed with hostess staff on Meal Service/Feedings policy #13 from Patient Food Services Policies & Procedures Volume IV stating unit pantry refrigerators must be cleaned and sanitized. This was done by Manager of Patient Services. A new log was created for documentation on refrigerator cleaning and sanitizing and is to be completed	05/09/2014

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	of review and revision of 9/25/2013, indicated: a. under "Procedure", in section 2. "Hospitality Associate may do the following:...J. Clean and sanitize designated unit pantries refrigerators..." 2. at 12:15 PM on 4/14/14, while on tour of the ED (emergency department) in the company of staff member #56, the ED director, it was observed that the pantry refrigerator was dirty on two of the shelves of the door (with a red, dried liquid substance on the top shelf of the door) and had a dusty bottom shelf of the refrigerator 3. at 12:20 PM on 4/14/14, interview with staff member #56 indicated agreement that the refrigerator was dirty as noted in 2. above 4. at 3:27 PM on 4/14/14, while on tour of the NICU (neonatal intensive care unit) in the company of staff member #69, the unit nurse manager, it was observed in the pantry area that the refrigerator was dusty on top 5. interview with staff member #69 at 3:30 PM on 4/14/14, indicated it was agreed that the top of the refrigerator had an accumulation of dust present		by unit hostesses daily. This process will be monitored during weekly pantry rounds.	

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	6. at 11:30 AM on 4/15/14, while on tour of the ICU (intensive care unit) in the company of staff member #63, the nurse director of the unit, it was observed in the main pantry that the rubber seal on the door of the refrigerator had debris, crumbs, spilled liquids in the folds of the seal and had debris/crumbs and was sticky on the bottom shelf of the freezer portion of the appliance 7. interview at 12:05 PM on 4/15/14 with staff member #77, the dietician and dietary director, indicated: a. observation of the ICU refrigerator indicated it was dirty as listed in 4. above b. dietary aides/associates/patient service reps are responsible for cleaning pantry refrigerators daily when stocking them, as per facility policy c. the dietary associates do not log when a refrigerator is/was cleaned so it is not clear the last time the ICU refrigerator was cleaned			
S000556	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b) (b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention			

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	of infections and communicable diseases in patients and health care workers. Based on review of the infection prevention plan, observation, and interview, the infection control committee failed to ensure an active effective control program in relation to off site housekeeping monitoring at one location toured (146th street, Noblesville) Findings: 1. review of the "Infection Prevention Plan", with an effective date of 03/2014, (IPP#-00-IP Plan) indicated: a. under "Statement of Purpose:": "...Infection Prevention activities take place in all patient units, ancillary hospital departments, and off site departments that are part of the hospitals licensure and therefore report through the Hospital Infection Prevention Committees..." 2. at 9:00 AM on 4/15/14, while on tour of an off site imaging center in the company of staff member #53, the ambulatory site leader, and staff members #64 and 65, off site managers, it was observed that: a. in the CT (computed tomography) room, the top of the CT scanner was dusty b. in the hallway housekeeping closet	S000556	Findings 1,2: Accountable leader: Director of Community Imaging CentersCorrection Date: 5/5/14Correction: Created a detailed daily/weekly room cleaning log for all CT rooms to include the top of the CT scanner. This log will be kept in the control room and will be initialed by the technologist after and cleaning is complete. In addition all technologists have signed the room cleaning process and a copy will be kept in employees department file. Findings 3,4:Accountable leader: Site Leader Infection ControlCorrection Date: Incremental Phase 1: 5/16/14, Phase 2: 6/16/14Correction:1) Infection Prevention team met to confirm improvement strategy (incremental phase 1 date)2) Ambulatory Care Infection Preventionist has been hired to round and monitor all off site locations annually. Rounding on all off site facilities will be completed by 6/16/2014 (incremental phase 2 date)3) Summary and any essential follow up regarding off site rounds will be reported at the Infection Prevention Committee meetings,with first report to the next meeting, scheduled on May 19th, 2014 (incremental phase 2 date).4) Cleaning products used by the above contract companies	05/16/2014

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	there was a bottle of pH7Q Ultra disinfectant 3. interview with staff members #64 and 65, it was indicated that a contracted housekeeping company (QBM-quality building maintenance) cleans the facility after hours 4. interview with staff member #80, the infection preventionist, at 10:30 AM on 4/15/14, indicated: a. the infection control committee is not currently monitoring the off site imaging locations b. infection control committee meetings are lacking reports of surveillance and infection prevention activities to date c. the infection control committee has not approved of the cleaning processes used by QBM ("Clinical Training Procedures" d. the infection control committee has not approved of the cleaning products used by QBM in cleaning the off site locations they provide services at (it was unknown that the pH7Q Ultra product was being used)		will be reviewed annually or as needed and placed on the Infection Prevention Committee agenda to be approved, starting with the next meeting on May 19th, 2014 (incremental phase 2 date). 5) The Ambulatory Care Infection Preventionist will monitor disinfectants/cleaners during annual rounds. This is in process, and is being recorded on checklist during rounds (incremental phase 2 date)	
S000592	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i) (f) The hospital shall establish an			

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	infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (i) Sanitation. Based on policy and procedure review and interview, the infection control committee failed to ensure the disinfection and sanitation of the floors in patient rooms, as per facility policy. Findings: 1. review of the policy and procedure "Infection Prevention Policy for Standard Precautions", effective 01/2013, number IPP#13, indicated on page 2 under section 9. "Environmental Control A. Clean blood body fluid spills as soon as possible...Use a hospital disinfectant to decontaminate the area..." 2. review of the policy "Wet Mopping - Single Bucket", "Proceure No: 3", last reviewed on 04/01/13, indicated in the Equipment area that "Hospital Approved Germicide" was included in the equipment needed along with the "Hospital Approved Cleaner", but the	S000592	Findings: All Accountable leader: Site Leader Infection PreventionCorrection Date: Incremental Phase 1: 5/16/14, Phase 2: 6/16/14Correction: 1) Infection Prevention team met to confirm improvement strategy (incremental phase 1 date)2) In-house Environmental Services (EVS) will continue to have active participation on the Infection Prevention Committee and will advise infection preventionists when changes in practice/products occur. Representation for the off site EVS companies will be added to the Infection Prevention Committee starting with the May 19th, 2014 meeting (incremental phase 2 date), and will advise infection preventionists as above.3) Ambulatory off site leadership will be added to the Infection Prevention committee as of the May 19th, 2014 meeting (incremental phase 2 date).4) EVS policies/procedures	05/16/2014

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	policy is not specific as to what product to use on which surfaces 3. review of the policy "Dismissal Room Cleaning", "Procedure No: 7E/S/N/H", last reviewed on 04/10/13, indicated: a. in the "Equipment" section, it indicates that a "Hospital Approved Germicide" is used (no mention of a general/multi purpose cleaner) b. under "Policy:", it reads: "All non-precaution dismissal and transfer rooms will be cleaned according to this procedure. All employees will comply with I.P.C. #13 "Standard Precautions"." c. under "Procedure", it reads: "...3. Prepare germicide solution according to label instructions...1.. Prepare to wet mop tile floors with germicide solution..." 4. at 12:15 PM on 4/15/14, while on tour of the G-2 surgical unit in the company of staff members #60, the nurse director, and #61, the nurse manager, the housekeeper, staff member #81, was interviewed and indicated: a. the Tri base product is used on the floors for cleaning daily and with terminal cleaning after a patient is discharged b. only patients with C-Diff have their room and floors cleaned with a bleach solution, all other patient rooms with infections are still cleaned with a general		for disinfection and sanitation of patient care areas will be reviewed and placed on the Infection Prevention Committee agenda to be approved annually and as needed (incremental phase 2 date).5) Patient care areas will no longer be cleaned with general cleaner, but with GS Neutral disinfectant. This product was aproved by Safety and Infection Prevention. EVS staff will be trained and product to be in use by June 1, 2014 (incremental phase 2 date).	

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	purpose cleaner with terminal cleaning c. the Tri base product is a general purpose cleaner and not a disinfectant 5. at 1:15 PM on 4/15/14, interview with staff member #82, the EVS (environmental services) director, indicated: a. the Tri base product is a general purpose cleaner and not a disinfectant b. currently, the facility is only using the general purpose cleaner, and not a disinfectant, on patient room floors, both daily and with terminal cleaning c. it cannot be determined by housekeeping staff if there were any blood/body fluid spills in the patient's room prior to discharge, and if they were properly disinfected at that time, so that the standard precaution policy, listed in 1. above, should be followed by housekeeping staff during terminal cleaning processes, including disinfection of the floor 6. at 2:15 PM on 4/15/14, interview with staff member #80, the infection preventionist, indicated: a. it was unknown by this practitioner that only general purpose cleaner was being used for daily and terminal cleaning of patient room floors b. the infection control committee has not approved of the EVS policies (see 2			

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	and 3 above) which related to disinfection and sanitation of patient care areas c. it cannot be determined by housekeeping staff if there were any blood/body fluid spills in the patient's room prior to discharge, and if they were properly disinfected at that time, so that the standard precaution policy, listed in 1. above, should be followed by housekeeping staff during terminal cleaning processes, including disinfection of the floor			
S000912	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job			

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	descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. Based on pediatric medical record review and interview, the nurse executive failed to ensure that standards of practice and facility processes were implemented related to OFC (occipital/frontal circumference) assessment on admission for 2 of 2 children less than two years of age, pts. #11 and #12; failed to ensure the implementation of the policy related to blood glucose control solutions in one area toured; and failed to ensure the implementation of the Cardiopulmonary Resuscitation policy in relation to cleaning crash carts. Findings: 1. review of two open pediatric medical records indicated: a. pt. #11 was a 13 month old admitted on 4/15/14 who lacked documentation in the medical record of an OFC measurement b. pt. #12 was a 10 month old admitted	S000912	Findings 1-4Accountable leader: Director Neonatal ServicesCorrection Date: 5/16/14Correction:1. Information Technology - EPIC/CareConnect Concerns · For the documented and “lost” head circumference on the two pediatric patients examined during the recent CHN ISDH survey: · CareConnect resources were unable to locate any documentation for head circumference for the two selected patients, current or deleted. There was no indication that a head circumference had ever been documented on either of the selected patients. Unfortunately, neither caregiver was able to provide the details (time, date, value) of the documentation in question, so we are unable to examine if this documentation may have been entered on an incorrect patient. · Thorough testing revealed that the EPIC system is working properly to document head circumference. Head	05/16/2014

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	on 4/15/14 who lacked documentation in the medical record of an OFC measurement 2. at 12:00 PM on 4/16/14, interview with staff member #74, the charge nurse who admitted pt. #11 on 4/15/14, indicated: a. this staff nurse measured the OFC for pt. #11 on admission and entered it into EPIC (computer charting system) at that time (in the vital signs section) b. OFC is not a "default" in the vital signs charting area, it must be entered by a separate, extra, method by nursing staff c. the OFC documentation cannot be viewed on the computer at this time d. there have been "issues" with the EPIC system not saving nursing data at times 3. at 12:10 PM on 4/16/14, interview with staff member #75, the pediatrics nurse manager, it was indicated that: a. the tech measured the OFC on patient #12 on 4/15/16 and entered the data in the vital signs section of the electronic medical record b. the standard of practice is that OFC should be measured on admission for any pediatric patient less than 2 years of age 4. interview with staff member #76, a clinical resource nurse, at 12:15 PM on		circumference data does not disappear, and can be retrieved. We are unable to reproduce a scenario of “lost” head circumference documentation. · We are able to successfully view head circumference documentation for other pediatric patients hospitalized during a similar timeframe. · As requested, on April 25th the pediatric Head Circumference EPIC flowsheet row was added to the RN assessment flow sheet so that is now visible to the RNs without needing to add the row. 2. Compliance Audit· To ensure compliance, each month the pediatric manager will audit all charts of patients <2 years of age for admission documentation of OFC. · The audits will take place for a minimum of 2 months and will continue until there are two consecutive months of audits that are ≥ 90% compliant. · Audit report will be sent to Site Leader Quality Resources at the end of each month. Findings 5-7Accountable leader: Nurse Manager, Family RoomsCorrection Date: 5/9/14Correction: · Leadership (Nurse Manager) will re-educate the staff and charge nurses via email today, 5/9/14, and Staff Meeting on 5/15/14 with continual coaching and reminders done by the Leadership Team (Nurse Managers and Patient Care Coordinator) to assure hardwired	

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	4/16/14 indicated: a. there is no policy and procedure that indicates an OFC is required with the pediatric admission assessment, but this is a standard of practice and a required/expected process to be completed by staff b. OFC is not a "default" in the vital signs charting area, it must be entered by a separate, extra, method by nursing staff c. the OFC documentation cannot be viewed on the computer at this time for either patient #11 or #12 d. there have been "issues" with the EPIC system not saving nursing data at times 5. review of the policy and procedure "Blood Glucose Monitoring With the ACCU-CHEK Inform II System", policy number CORP#: POC-002, with an effective date of 08/27/2013, indicated: a. on page 5 under "D. Quality Control Testing", it reads: "1. Perform level 1 and Level 2 control tests...2. Store glucose control solutions at room temperature...3. Mark the label with a 90 day expiration date whenever opening a new control solution..." 6. while on tour of Family room/Maternity Services area in the company of staff members #66 and #67, nurse managers of the unit, it was		behavior. · Re-Education will consist of stressing the importance with writing the 3 month expiration date from date opened on each vial of control solutions and must be done 100% of the time. Also, when running the daily controls, the importance of checking the vials for that expiration date before using the solutions to assure integrity of the solutions. Also to discard the vials if no expiration date is written or if the date is outside the 3 month since opened window. · Quality Control check-step. Each night shift charge nurse will inspect all accuchek control solution vials for each of the accuchek machines every night to assure the expiration date is not only written but still within the 3 month window of when the vials were opened. · If no date is written or if the vials are expired outside of that 3 month window, the night shift charge nurse will discard the vials and replace with new control solutions, assuring the 3 month expiration date is written on each vial. · The night shift charge nurse responsibility of checking all solutions each night will take effect by Monday 5/12/14. Findings 8-18Accountable leader: CHN VP NursingCorrection Date: 5/9/14Correction:PCC or designee in ICU, PACU,	

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	observed on G-4-2 (fourth floor, pod 2) unit nursing station that the Level 1 and Level 2 bottles of control solution were not dated, making it unclear when the 90 days after opening would occur 7. staff member #66 agreed that the control solutions were opened for use and not dated with a 90 day expiration date, or any date at all 8. review of the "Cardiopulmonary Resuscitation" policy and procedure, policy number CORP#: CLN-2005, with an effective date of 4/25/12, indicated: a. on page 7, it reads in section c. "Maintenance and Checking of Crash Carts - (Appendix)--Daily--Each department is responsible for the cleaning, maintenance and inspection of the Crash cart(s) in the respective area..." 9. while on tour of the ED (emergency department) at 12:20 PM on 4/14/14 in the company of staff member #56, the director of the ED, it was observed that the top shelf of the crash cart (behind the respiratory therapy box) was dusty 10. interview with staff member #56 indicated agreement that there was an accumulation of dust on the top of the crash cart		Endoscopy, G Tower (second floor) and Emergency Department will clean/dust all crash carts every Wednesday when performing daily crash cart check. Documentation will be completed on the Crash Cart log. Managers will check the crash cart every Friday for compliance and monitor on the log. Nurse managers will provide instruction regarding the process by May 9th, and cleaning process will begin the week of 5/12/14.	

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	11. at 11:25 AM on 4/15/14, while on tour of the ICU (intensive care unit), in the company of staff member #63, the director of the unit, it was observed that the top of the crash cart (by room 2711) was dusty 12. staff member #63 agreed that there was an accumulation of dust present on the top of the crash cart 13. at 12:26 PM on 4/15/14, while on tour of the G-2 Surgical nursing unit in the company of staff members #60, the director of the unit, and #61, the nurse manager, it was observed that the crash cart, located in a hallway near the soiled utility, was dusty on the top of the cart 14. staff members #60 and #61 agreed that an accumulation of dust was present on the top of the cart 15. at 9:55 AM on 4/16/14, while on tour of the endoscopy area in the company of staff member #72, the nurse director of the unit, it was observed that the crash cart had an accumulation of dust on the top and back of the cart 16. staff member #72 agreed that there was an accumulation of dust present 17. at 10:05 AM on 4/16/14, while on			

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	tour of the pre/post op area in the company of staff member #72, the nurse director of the unit, it was observed that the crash cart was dusty on top 18. staff member #72 agreed that there was an accumulation of dust on the top of the crash cart			
S001028	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on observation and interview, the hospital failed to ensure a policy indicating who could access medications in 1 instance. Findings: 1. On 4-15-14 at 9:25 am in the presence of employee #A10, it was observed in the	S001028	Findings: AllAccountable leader: Human Recources ManagerCorrection Date: Incremental Phase 1: 5/16/14, Phase 2: 6/16/14, Phase 3: 7/16/14Correction:Administration of dexamethasone 0.33% phono gel is within the scope of practice for Physical Therapists per the American Rehab Association National Practice Guidelines.	05/16/2014

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	gym at the Rehab and Sports Medicine - Noblesville offsite, the medication Dexamethasone Phono 0.33% gel in a locked cabinet. The cabinet was opened by a hospital staff member who was identified as a Physical Therapist. 2. At that above time and date, employee #A10 was requested to provide documentation in the form of a hospital policy or job description which indicated a Physical Therapist had authority to access medications. The documentation provided did not indicate a Physical Therapist had authorization to access medications. 3. In interview, on 4-16-14 at 2:30 pm, the above was confirmed by employee #A10 and no other documentation was provided by exit.		However, administration of medications is not currently specified in the PT, OT, PTA, or COTA job descriptions. Administration of medications within the rehab scope of practice will be added as an Essential Function to these job description1) Leadership team confirmed improvement strategy (phase 1 implementation date)2) HR team will be notified to update job descriptions and begin process (phase 2 implementation date)3) Job description updates will be completed (phase 3 implementation date)	
S001118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or			

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	maintained which may result in a hazard to patients, public, or employees. Based on document review, observation, and interview, the facility failed to ensure that no condition was created that might result in hazard to patients, visitors, or employees in regards to expired supplies in clean store rooms, and dirty microwaves in patient pantry/nutrition rooms. Findings: 1. review of the OR (operating room) MH (malignant hyperthermia) cart schedule/calendar for April 2014 indicated the cart had been checked on April 3 and 10, 2014 2. while on tour of the OR at 10:50 AM on 4/16/14 in the company of staff members #72, the OR director, and #73, a surgery nurse, it was observed in the MH cart that the following supplies were expired: a. 5 angiocaths 20G, with an expiration date in 2013 b. 6 red top lab tubes that expired 2/14 c. >3 blue top lab tubes that expired January 2014 3. interview at 10:55 AM on 4/16/14 with staff members #72 and #73 indicated:	S001118	Findings 1-7 Accountable leader: Clinical Director, Surgical ServicesCorrection Date: 5/16/14Correction: Responsiblity for checking the Malignant Hyperthermia cart will be assigned to rotating staff, rather than to one individual. This will familiarize more staff with the cart and contents. Staff are expected to physically open and check each drawer, rather than relying on the last reported "out date" item listed. Plan was finalized on 4/30/14. The assignment calendar will be completed on May 9th. Announcement to staff will occur at May 16th staff meeting, with implementation of the new process. Findings 8,9Accountable leader: Nursing Director, ICU Correction Date: 4/17/14Correction: Rack in ICU pantry was removed and disposed of.Findings 10-15:Accountable leader: VP NursingCorrection Date: 5/12/14Correction: PCC or designee will clean microwaves in departments on Wednesday. Documentation will be completed on Microwave Cleaning Log. Manager or designee will check the microwaves weekly for cleanliness and document on Microwave Cleaning Log. Nurse Manager will provide education regarding the process by May 9th and cleaning process will begin	05/16/2014

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	a. besides previous months' checks, the MH cart was signed off on April 3 and April 10 as having been checked b. the expired supplies found, and listed in 2. above, should have been detected and discarded during previous cart checks by staff 4. at 10:20 AM on 4/16/14, while on tour of the OR in the company of staff members #72, the OR director, and #73, a surgery nurse, it was observed in the pre/post op clean utility room that the following culture swabs were expired: a. 2 that expired 3/14 b. 1 that expired 10/13 c. 1 that expired 9/10 5. interview at 10:25 AM on 4/16/14 with staff members #72 and #73 indicated CSR (central supply room) staff are to monitor the expiration dates when they restock the nursing units 6. at 10:35 AM on 4/16/14, while on tour of the OR in the company of staff members #72, the OR director, and #73, a surgery nurse, it was observed in the clean supply room that a box with >10 PDS II (4-0) sutures had expired 1/2014 7. staff members #72, the OR director, and #73, a surgery nurse, agreed at 10:40 AM on 4/16/14 that the suture was		the week of May 12th.	

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	expired 8. at 11:40 AM on 4/15/14, while on tour of the ICU (intensive care unit) in the company of staff member #63, the unit director, it was observed that there was a food tray storage rack in the corner of the main pantry that was dirty on the lower portion of the rack 9. interview at 11:40 AM on 4/15/14 with staff member #63 indicated: a. the storage rack was grossly dirty b. the rack is no longer used and should be removed from the pantry area 10. at 2:15 PM on 4/14/14, while on tour of the Family Rooms/Maternity Services area in the company of staff members #66 and #67, nurse managers, it was observed in the pantry area that the microwave was very dirty with dried splatters on all of the walls and rotating glass shelf 11. interview with staff members #66 and #67 at 2:20 PM on 4/14/14 indicated: a. there is no facility policy related to the cleaning of microwaves b. it is a joint responsibility between nursing and EVS (environmental services) staff to keep the microwaves clean			

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	12. at 3:25 PM on 4/14/14, while on tour of the NICU (neonatal intensive care unit) in the company of staff member #69, the nurse manager, it was observed in the pantry area that the microwave glass turntable had a dried spilled liquid present 13. staff member #69 agreed that the microwave was dirty 14. at 12:25 PM on 4/15/14, while on tour of the G-2 surgical floor in the company of staff member #60, the unit director, it was observed that the back wall of the microwave was dirty with dried splatters 15. staff member #60 agreed that the microwave was dirty			
S001164	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (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: (B) There shall be evidence of			

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	preventive maintenance on all equipment. Based on document review, observation and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 3 pieces of equipment and failed to maintain the blanket warmers as per manufacturer's recommendations. Findings: 1. On 4-15-14 at 9:25 am, hospital staff was requested to provide documentation of PM on a shoulder pulley located at the Rehab and Sports Medicine offsite in Noblesville. No documentation was provided by exit. 2. On 4-15-14 at 11:10 am, employee #A14 was requested to provide documentation of PM on the Code Blue buttons located in the operating rooms and the recovery area. In interview, at 2:10 pm on 4-16-14, the employee indicated there was no PM documentation for the Code Blue buttons and no other documentation was provided by exit. 3. On 4-15-14 at 11:10 am, employee #A14 was requested to provide documentation of PM on a floor scrubber. In interview, at 2:15 pm on	S001164	Finding 1 - Shoulder pulley Accountable leader: North Market Physical Therapy and Rehab Mrg. Correction Date: 5/16/14Correction: Clinical Engineering verified the safety of the shoulder pulley and placed an inspection tag on the equipment. The pulley has been added into the routine inspection rotation. Ongoing compliance will be monitored through quarterly leadership rounds of the clinic.Finding 2 - PM for OR code buttonsAccountable leader: Director of FacilitiesCorrection Date: 5/2/14Correction: Annual PM written to test OR code buttons and system tested on 4/17/14. Finding 3 - PM for floor scrubberAccountable leader: Director of FacilitiesCorrection Date: Interval 1: 5/16/14, Interval 2: 6/1/14 Correction: Quarterly PM written to document testing/repairs of Environmental Services (EVS) equipment by EVS staff (due for completion Interval date #1). Inventory of EVS equipment updated (due for completion Interval date #2).Finding 4 - Cleaning of Skytron Blanket Warmers Accountable leader: Director of FacilitiesCorrection Date: 5/2/14 Correction: PM schedule re-established for blanket warmers at CHN to open	05/16/2014

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	4-16-14, the employee indicated there was no PM documentation for the scrubber and no other documentation was provided by exit. 4. review of the Skytron Warming Cabinets owner's manual indicated on page 14, in section 3-2. "Preventive Maintenance": a. "a. Every 6 months - Cleaning...2."..Remove all contents and clean all shelving Clean all interior chamber walls, floor and ceiling starting at the top and working down..." b. "b. Every year - Internal Cleaning Removal of the interior plenum panels: 1. Remove the bottom spill pan with the four Phillips head retaining screws two in each side. 2. Remove the bottom plenum by removal of the four Phillips head screws at the front edge...6. Clean all exposed surfaces with a damp cloth and mild non abrasive detergent..." 5. at 10:25 AM on 4/16/14, while on tour of the post op area of the surgical department in the company of staff member #72, the nurse director, it was observed that the Skytron warming cabinet: a. had a gross amount of accumulated dust on the lowest shelf that flew about when opening the door of the warmer b. had dust flowing out of the holes in the plenum shelf of the top cabinet of the		units for cleaning Monitoring (for all Facility Management corrections):1) Semiannual building walk through by Facilities and Safety leadership to identify and resolve any safety or equipment issues.2) Weekly rounds with Facilities and Infection Prevention leadership to identify and resolve equipment or facility issue for new construction or project areas.	

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	same blanket warmer 6. interview with staff member #79, the facility maintenance director, at 1:55 PM on 4/16/14, indicated that currently the blanket warmers are not on a 6 month and annual cleaning schedule as required per manufacturer's recommendations			
S001172	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on observation and interview, the facility failed to ensure cleanliness of the facility in 5 areas toured. Findings: 1. at 2:10 PM on 4/14/14, while on tour of the Family Rooms/Maternity Services	S001172	Finding 1,2 - Family Rooms Clean Utility Shelves - Dust and DebrisAccountable leader: Site Manager Environmental ServicesCorrection Date: 5/12/14Correction: The bottom shelves in Family Rooms/Maternity Services clean utility rooms have been added to	05/16/2014

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	unit in the company of staff members #66 and #67, the nurse managers, it was observed that in pod 4, the clean utility room had a shelf near the floor that supplies were stored upon that was dusty and with debris 2. staff members #66 and #67 agreed that the low shelf needed to be cleaned 3. at 9:00 AM on 4/15/14, while on tour of the off site imaging center (146th street Noblesville) in the company of staff member #54, the ambulatory site leader, it was observed that there was dust on the top of the CT (computed tomography) machine 4. at 9:05 AM on 4/15/14, staff member #54 agreed that there was a small amount of dust present on the top of the CT machine and that at this time, no one is monitoring the off site contracted housekeeping services 5. at 12:20 PM on 4/15/14, while on tour of the G-2 surgical unit in the company of staff member # 60, the unit director, it was observed that the floor of the "front" clean storage room (by patient room 2200) was dusty and had debris present--a gross amount of dust behind the ready bath product cart		the daily cleaning schedule and will be verified by Environmental Services supervisor on daily basis to ensure completion. Finding 3,4 - CT Scan Ambulatory Site Accountable leader: Director of Community Imaging CentersCorrection Date: 5/5/14Correction: Created a detailed daily/weekly room cleaning log for all CT rooms to include the top of the CT scanner. This log will be kept in the control room and will be initialed by the technologist after and cleaning is complete. In addition all technologists have signed the room cleaning process and a copy will be kept in employees department file. Findings 5,6 - G2 Clean Utility Room - DustAccountable leader: Site Manager Environmental ServicesCorrection Date: 5/12/14Correction: The frequency of dust mopping/cleaning of floors in G2 clean utility rooms has been increased to the daily cleaning schedule and will be verified by Environmental Services supervisor on daily basis to ensure completion.Findings 7-9 - Skytron Booms - DustAccountable leader: Site Manager Environmental ServicesCorrection Date: 4/18/14Correction: Environmental Services employees have been re-educated on the OR cleaning procedure specific to high dusting booms and vents in OR Suites.	

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	6. interview at 12:25 PM on 4/15/14 with staff member #60 indicated the floor of the clean storage room was grossly dirty 7. at 11:20 AM and 11:30 AM on 4/16/14, it was observed in the Family Rooms/Maternity Services Area surgical suites I and II in the company of staff members #66, the nurse manager, and #78, the maternity anesthetist, that the Skytron booms near the ceiling (with gasses and electrical components) had accumulated dust that could be observed while standing on the floor and looking above 8. at 11:35 AM on 4/16/14, while on tour of OR I in the Family Rooms/Maternity Services Area in the company of staff members #66, the nurse manager, and #78, the maternity anesthetist, that the back wall vent was extremely dusty on the slats of the air vent (especially in the corners) 9. at 11:35 AM on 4/16/14, staff members #66 and #78 agreed that housekeeping services needed to improve their cleaning of the Skytron booms and wall vents 10. at 11:45 AM on 4/16/14 while on tour of the endoscopy unit in the		This is to be verified by Environmental Services supervisor on daily basis to ensure completion. Finding 10,11 - Endoscopy Unit Light Screen Covers - DustAccountable leader: Site Manager Environmental ServicesCorrection Date: 5/12/14Correction: The screen covered lights have been placed on a weekly rotation to ensure dust does not accumulate in overhead light fixtures. This is to be verified by Environmental Services supervisor on a weekly basis to ensure completion.	

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	company of staff member #71, the administrative staff member/scribe/tour director, it was observed that one of the overhead lights in the nursing station area had a screen covering that was grossly dusty 11. staff member #71 agreed that the screen/cover was dusty and that housekeeping staff needed to clean the light cover			
S001216	410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(b)(1)(A)(B)(i)(ii) (iii)(iv)(v)(C) (b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows: (1) Proper safety precautions shall be maintained against radiation hazards in accordance with the hospital's radiation and safety program as developed by the radiation safety officer. This includes, but is not limited to, the following: (A) Adequate shielding for patients, personnel, and facilities. (B) Procedures for monitoring: (i) skin dosage; (ii) radionuclide contamination; (iii) quality control; (iv) technique charts, where			

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	applicable; and (v) handling of hazardous materials. (C) Appropriate storage, use, and disposal of radioactive materials. Based on policy and procedure review, document review, and interview, the radiation safety officer failed to ensure clarity related to the storage, or transport, of imaging badges for employees at one imaging off site location. Findings: 1. review of the policy and procedure "Medical Imaging Department Policy and Procedure", RS NO: 2, with a review date of 07/13, indicated: a. on page 3, in item 10., it reads: "Radiation badges may leave the department in the event the technologist travels between multiple locations. Badges must be stored properly avoiding heat or direct sunlight." 2. at 9:00 AM on 4/15/14, while on tour of the off site imaging center on 146th street in Noblesville, staff members #64 and #65, managers of the center, indicated the imaging staff take their radiation badges with them at the end of a shift and travel to other off site imaging locations 3. at 8:55 AM on 4/16/14, review of the note from the Director of Medical	S001216	Findings 1-4 Accountable leader: Director of Community Imaging CentersCorrection Date: 4/25/14Correction: The Radiation Safety Officer (Andrea D. Browne, Ph.D.) on 4/25/2014 included in policy RS NO: 106 Radiation Safety Monitoring Devices on page 2 section 7 row I: A monitored individual may transport and use an assigned monitor at more than one location within the CHN. Department policy RS NO: 2 was removed and RS NO: 106 is the network policy that will be used. All Imaging Center staff have been notified by email on 5/6/2014. This was completed by the Director of Community Imaging Center North/East markets.	05/16/2014

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	Imaging, who had spoken with the Radiation Safety Officer, indicated that "...if a staff member works at two locations within the network they would have a badge at both locations." 4. interview with staff member #54, the facility ambulatory site leader, at 3:30 PM on 4/16/14, indicated: a. with the conflict between what policy RS NO: 2 reads (badges may travel between locations), and what the Radiation Safety Officer stated was facility policy/process (staff to have a badge at each location worked and not to be traveling with staff), it is unclear what the imaging staff are actually to do with radiation badges when traveling between more than one facility imaging location			
S002116	410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8(c)(1) (c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows: (1) A mechanism shall be maintained which specifies the delineated surgical privileges of each practitioner. Based on policy and procedure review	S002116	Findings 1-6 (dangling surgical	05/16/2014

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	and observation the facility failed to ensure that the policy related to surgical attire was implemented in 5 instances. Findings: 1. review of the policy and procedure "Surgical Attire", policy number NPP: ORSPP: A-1, with an effective date of 9/16/10, indicated: a. under "Policy Statements", in item C., "Masks", it reads: "...2. Masks will be removed (and replaced) between cases and when soiled or wet. 3. Masks are carefully removed and discarded after use by handling only the ties. They are not to be saved by hanging around the neck or tucking into a pocket for future use..." b. under "Policy Statements", in item D., "Name Badges/Jewelry", it reads: "For all OR (operating room) personnel entering semi-restricted area: remove rings, watches and bracelets. Other jewelry must be totally confined within scrub attire or removed." 2. while in the first floor hallway on the way to tour the ED (emergency department) at 11:20 AM on 4/14/14, in the company of staff members #54, the ambulatory site leader, and #55, a risk manager, it was observed that an anesthesiologist was ambulating in the public hallway with their surgical mask tied at the back of their head and neck and dangling down about the neck		masks and exposed or dangling earrings) Accountable leader: Clinical Director, Surgical ServicesCorrection Date: 5/16/14Correction: Confirmed current policy is adequate. Staff Education - 5/2/14 Weekly newsletter for OR team with a link to AORN Best Practice standards related to surgical masks. 5/5/14 Weekly Newsletter for all staff with education specific to proper wearing of surgical masks. Surgery leaders will continue to monitor for non-compliance with immediate follow-up.	

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	3. at 9:40 AM on 4/16/14, while on tour of the endcoscopy area in the company of staff member #72, the director of surgical and endo services, it was observed that a RT (respiratory therapy) staff member came out of one patient room and entered a work room with their surgical mask down and under their chin--this staff member then exited the work room and walked about the endo area continuing to wear the surgical mask about the neck 4. at 10:25 AM on 4/16/14, while on tour of the surgery area in the company of staff members #72, the director of surgical and endo services, and #73, a surgical nurse, it was observed that an anesthesiologist entered a recovery room bay with a patient from the OR and had their surgical mask down about the neck--the anesthesiologist then exited the recovery area, leaving the surgery department, and continued to have their mask dangling about the neck 5. at 10:37 AM on 4/16/14, while on tour of the surgery area in the company of staff members #72, the director of surgical and endo services, and #73, a surgical nurse, it was observed in the instrument decontamination area, a nurse was present, and conversing with the decontam tech, with their surgical mask tied behind their head and dangling about the neck 6. at 10:40 AM on 4/16/14, while on tour			

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	of the surgery area in the company of staff members #72, the director of surgical and endo services, and #73, a surgical nurse, it was observed that a support tech was ambulating in the surgical hallways with dangling earrings not confined within the surgical cap and the director of surgery had post type earrings exposed and not covered by the surgical cap			