

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150074	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/26/2016
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219
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S 0000  Bldg. 00	<p>This visit was for investigation of one hospital licensure complaint.</p> <p>Date: 4/25/16 - 4/26/16</p> <p>Facility Number: 005068</p> <p>Complaint Number: IN00195520</p> <p>Substantiated; deficiency related to the allegations is cited. Deficiency unrelated to the allegations is cited.</p> <p>QA: cjl 05/04/16</p>	S 0000		
S 0608  Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL</p> <p>410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an 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:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work</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>settings. Based on document review, observation and interview, the infection control practitioner failed to ensure that nursing staff implemented the policy related to PPE (personal protective equipment) for 2 of 2 contact precaution patients on the Cardiac PCU (progressive care unit), patient #10 and patient #11.</p> <p>Findings Include:</p> <p>1. Review of the policy: Infection Prevention Policy for Contact Precautions, IPP# 01-C, reviewed/ revised 2/2016, indicated on page two under "Text" in 1. B.: "Change protective attire and perform hand hygiene between contacts with patients in the same room." And, on page 3., under "4. Gowns", it reads in C. "Gown must be removed before leaving the patient room. D. If gown is needed outside the patient room, a clean gown must be worn."</p> <p>2. At 2:06 PM on 4/25/16, while touring the Cardiac PCU, it was observed that 2 face masks were hanging on the door handles of room of patient #11 where the patient was noted to be in contact precautions.</p> <p>3. At 2:08 PM on 4/25/16, on the Cardiac PCU, it was observed that an</p>	S 0608	<p>1.How are you goingto correct the deficiency? If alreadycorrected, include the steps taken and the date of correction.</p> <p>1.BIYE (Bug in YourEar) Infection Prevention newsletter sent out on 5/17/16 highlighting that PPEis not to be reused and is single use only.</p> <p>2.All Safety Coacheswere educated at the May Safety Coach meeting on 5/3/16 to observe for gowns or masks being reused. If found, safetycoaches will correct the behavior on the spot and report incident to themanager.</p> <p>3.Annual InfectionPrevention education provided to all employees has been updated to highlightinfo on no reuse of PPE. This is included in the Annual Mandatories required byall employees.</p> <p>4.Periodicmonitoring of isolation rooms by nursing unit managers and/or IP will occur sporadicallywith on the spot correction of any errors found.</p>	05/17/2016	

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	<p>isolation gown was hanging on the entry door to room where the patient, patient #10 was noted to be in contact precautions.</p> <p>4. At 2:06 PM on 4/25/16, interview with staff members #59, the RN (registered nurse) unit manager and #51, the infection preventionist, confirmed that masks were hanging on the door handles of patient #11's room and should not be stored there for future use after having already been worn.</p> <p>5. At 2:08 PM on 4/25/16, interview with staff members #59 and #51 confirmed that a protective gown was hanging on the door of patient #10's room and should not be there.</p>		<p>1. How are you going to prevent the deficiency from recurring in the future?</p> <p>1. Update to annual Infection Prevention education has occurred. This education is a mandatory requirement for all employees annually.</p> <p>1. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <p>1. Infection Preventionist created and distributed BIYE newsletter to all nursing units. IP worked with annual education content writer to update education to include information on no reuse of gowns or masks in isolation rooms.</p> <p>2. IP provided update to Safety Coaches at May Safety Coach meeting.</p> <p>3. IP informed nursing managers that they should monitor for inappropriate reuse of gowns or masks in the isolation rooms on their units.</p>		

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S 0754 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)  (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:		<p>1. By what date are you going to have the deficiency corrected?</p> <p>1. You must provide a specific date the deficiency will be or has been corrected (month, day, and year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey.</p> <p>BIYE newsletter distributed on 5/17/16. Annual education update will be inserted and appear in the 2017 annual Infection Prevention education. Safety Coaches were informed of issue and the need to monitor on their units at meeting that occurred on 5/3/16. Managers were informed of deficiency during the 4/27/16 Daily Safety huddle.</p>	
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	<p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and interview, the facility failed to ensure that authorization for admission and treatment was obtained in 4 of 6 closed patient medical records reviewed, patients #2, 3, 4 and 6.</p> <p>Findings Include:</p> <p>1. Review of the policy: Consent for Medical Treatment, policy number CLN-2026, effective 10/1/15 and "cancels: 4/15/13; 6/4/13", indicated under "Purpose": 1. To assure compliance with Indiana and federal law pertaining to the requirement of an informed consent for medical treatment. Under "Policy Statements", it reads: 1. All inpatients and emergency room patients must sign (or have signed on their behalf) the Patient Consent Agreement at the time of admission for general medical services.</p> <p>2. Review of closed patient medical records indicated patients #2, #3, #4 and #6 had no forms in their medical records indicating they, or someone on their behalf, signed giving consent for</p>	S 0754	<p>Be sure that each individual Plan of Correction answers the following questions:</p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>Communication has gone out regarding the requirement to obtain consents on all emergency room patients, inpatients, and a yearly consent for outpatients.</p> <p>Monthly auditing of 30 charts per month starting as of May 1st. Staff educated on deficiency and following the Corrective Action policy.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p>	05/20/2016

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	<p>admission and treatment to the facility.</p> <p>3. At 9:35 AM on 4/26/16, interview with staff member #50, the risk management coordinator, confirmed that the medical records department could not locate any consents for admission and treatment for patients #2 and #3.</p> <p>4. At 10:50 AM on 4/26/16, interview with staff member #50 confirmed that, per the medical records department, no consents for admission and treatment could be found for patients #4 and #6 and that is unclear why the admissions process failed for patients #2, #3, #4 and #6.</p>		<p>Supervisors will conduct consistent auditing. IT has built work queue rules within EMR to identify patients without consents. Education for patient access/ registration personnel on this topic..</p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <p>Patient Access Team Lead, Supervisor, Manager, and Director.</p> <p>4. By what date are you going to have the deficiency corrected?</p> <p>1. You must provide a specific date the deficiency will be or has been corrected (month, day, and year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey.</p> <p>05/20/2016</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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