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	150074	A. BUILDING 00 B. WING	08/28/2014

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S000000	This visit was for a standard licensure survey. Facility Number: 005068 Survey Date: 8-25/28-14 Surveyors: Jack I. Cohen, MHA Medical Surveyor Linda Dubak, RN Public Health Nurse Surveyor Cleone Peterson Medical Surveyor QA: claughlin 09/19/14 IDR Committe met 10-17-14. Tag A0554 items were moved to A Tag 1022 per facility request. Tag A0952 modified per facility request.	S000000		
S000270	410 IAC 15-1.4-1			

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

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	GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up. Based on document review and interview, the governing board failed to review reports of quality activities for 4 contracted service for calendar year 2013. Findings: 1. Review of the governing board minutes for calendar year 2013 indicated they did not include review of reports for the contracted services of audiology, biohazard waste hauler, mobile Positron Emission Tomography (PET) scanner, and Visionary Enterprises, Inc. (VEI) housekeeping services provided at Regional Cancer Center Indianapolis offsite. 2. In interview on 8-28-14 at 11:35 am, employee #A23 confirmed the above and no further documentation was provided	S000270	As the Site Leader of Quality Resources, I am responsible to ensure all patient services provided under the East licensure have quality monitors and that the data has been reviewed through quarterly reports to the East Executive, Clinical and Operations management teams; the network Acute Care Operations Performance Council; the Quality of Care committee; and, ultimately to the Governing Board. The contracted services of audiology, biohazard waste hauler, mobile Positron Emmission Tomography (PET) scanner, and Visionary Enterprises, Inc. (VEI) housekeeping services provided at the East Regional Cancer Center are all present on the 2014 Quality Indicator Database report. A 2014 Reporting Schedule for the Quality Indicator Executive Summary and Annual	09/27/2014

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	prior to exit.		Evaluation was provided January, 2014 to ensure there is quarterly Quality Indicator data reporting from all patient service departments reported through said management committees and ultimately, to the Governing Board for review. See uploaded supporting documents for 2014 Quality Indicator data and the 2014 Quality Indicators Database Reporting Schedule.	
S000406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (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: (1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include monitors and standards for 3 services provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program for calendar year 2013. Findings:	S000406	As the Site Leader of Quality Resources, I am responsible to ensure all patient services provided under the East licensure including the contracted services have quality monitors and that the data has been reviewed through quarterly reports to the East Executive, Clinical and Operations management teams; the network Acute Care Operations Performance Council;	09/27/2014

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	1. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted services of audiology, mobile Positron Emission Tomography (PET) scanner, and Visionary Enterprises, Inc. (VEI) housekeeping services provided at Regional Cancer Center Indianapolis offsite 2. In interview on 8-28-14 at 11:35 am, employee #A23 confirmed the above and no further documentation was provided prior to exit.		the Quality of Care committee; and, ultimately to the Governing Board. The contracted services of audiology, mobile Positron Emmission Tomography (PET) scanner, and Visionary Enterprises, Inc. (VEI) housekeeping services provided at the East Regional Cancer Center are all present on the 2014 Quality Indicator Database report. A 2014 Reporting Schedule for the Quality Indicator Executive Summary and Annual Evaluation was provided January, 2014 to ensure there is quarterly Quality Indicator data reporting from all patient service departments reported through said management committees and ultimately, to the Governing Board for review. See uploaded supporting documents for 2014 Quality Indicator data and the 2014 Quality Indicators Database Reporting Schedule.	
S000554	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, interview, and document review, the hospital failed to follow the manufacturer's recommendation for testing a newly-opened test strip bottle to test	S000554	5-7. The Cardio-Pulmonary Site Director is the owner and responsible for the Cidex/Test Strip deficiency in the Pulmonary Rehab service that resides in the Healthy Hearts Clinic. The	08/28/2014

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	Cidex OPA in 1 instance Findings: 1. On 8-26-14 at 11:15 am, review of the Test Strip Log for CIDEX OPA Solution, located in the Healthy Heart area, indicated there was no documentation of testing of positive and negative controls on each newly opened bottle of CIDEX OPA Plus Solution Test Strips. 2. Review of the manufacturer's recommendation on the test strip bottle for test strips used for CIDEX OPA Solution, indicated it is recommended that the testing of positive and negative controls be performed on each newly opened test strip bottle of CIDEX OPA Solution Test Strips. 3. On 8-26-14 at 11:15 am, a Healthy Heart staff person indicated there was no documentation of this testing and no further documentation was provided prior to exit.		CIDEX OPA SOLUTION LOG SHEET and Control Log with Instructions (attached) has been in use since the last day of survey and clearly indicates when a new box of test strips has been opened, verified and completed. The Cardio-Pulmonary Site Director's 90 day plan (September through November) is to round through this area twice a week to ensure that this requirement is met by the testing staff member. Rounding will continue on this basis until evidence of the correct process according to manufacturer's guidelines is in practice by the testing staff member. With this evidence there will be ongoing random monitoring to ensure compliance of this process. The Infection Control Practitioner (ICP) had an educational session with the Pulmonary staff member responsible for testing. The ICP reviewed the need to complete the log sheet for each new bottle of test strips and why it is important to follow manufacturer's guidelines. The testing staff member indicated understanding and began using the new form immediately.	
S000952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)			

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	(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 transfusion record review, and staff interview, the facility failed to follow an approved medical staff policy/procedure for one of seven blood transfusions reviewed. Findings included: 1. Review of transfusion record #T4 indicated the the transfusion was started by the transfusionist at the same time as the blood was being released from the blood bank to a transporter. 2. In interview on 8/26/14 between 10:30 a.m. and 12:00 p.m., staff person #A22 acknowledged it is not possible to start a transfusion in the patient location at the same time the blood is being signed out from the Blood Bank to a transporter, who will then need to bring the blood to the patient location.	S000952	The Blood Management Officer is the owner and responsible for the blood management deficiency correction. 1-3) 9/19/2014 The Network Blood Management Officer met with the Education Specialist to present revisions to the Annual RN, LPN competency and the Non-Licensed Personnel competency in MyLearning. 9/23/2014 After receiving the final report from the ISDH the Network Blood Managment Officer had a phone meeting with the Education Specialist to add the following verbiage: "The ISDH reviews the documentation for blood product transfusions. On a recent visit to Community Health Network the surveyor noted that the time the blood was issued from the lab and the time the unit was documented as started were the exact same times. As this is not possible we received a citation. Please be accurate in your charting. It does matter." (attached updated Annual Blood Competency revision) The mandatory Annual RN, LPN competency and the Non-Licensed Personnel Blood	10/15/2014

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			Competency to be published for the staff testing on October 15, 2014 in MyLearning was also confirmed at this time. The Transfusion Record has been updated to include Transporter date and time and the Blood Bank Technician date and time as well. (attached) Monthly auditing of the Transfusion Record forms to ensure compliance will be done by the Network Blood Management Officer starting the following month after staff education. This means that 20 transfusion record forms will be reviewed per month starting November 1st through January 31st to ensure that correct practice and documentation have ocurred. Remedial education will be provided to those not compliant with policy. Continual evaluation of auditing of forms will occur after January evaluation, quarterly or until correct practice and documentation have occurred. IDR: The Blood Component Administration NPP# I-14B1 EFFECTIVE 7/17/12 policy that Cleone Peterson Medical Surveyor submitted appears to have been utilized on our 2013 survey with changes made only to the date and times. The area in the blue box with reference to the Blood Component Adm. NPP#I-14B1 EFFECTIVE: 7/17/2012(screen shot attached) references the 2013 survey policy	

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			date and supporting documentation does not support the citation for a transporter being unable to transport and start blood at the same time. We are not disputing the citation only the references to the outdated policy instead of our current policy I14-B1Blood Administration policy from 8/8/2013 (attached). Under "General Information" B. Obtaining Blood Component(s) from the Blood Bank 4. The transporter then signs the Transfusion Record form(s) in the area TRANSPORTED BY along with the date and time, and the department where the transfusion will take place.	
S001020	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(A) (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: (A) Separation of drugs designed for external use from drugs intended for internal use. Based on interview, the hospital failed to ensure the monthly inspection of 1 area where drugs are stored. Findings:	S001020	The Director of Pharmacy is the owner and responsible for the issue correction and oversight of the medication storage inspection process. 1) This issue was corrected by the	09/11/2014

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	1. On 8-25-14 at 1:50 pm, in the presence of employees #A19 and #A20, it was observed in the Healthy Heart area, there were medications stored in a secure storage device. 2. On 8-25-14 at 2:20 pm, in the presence of employees #A19 and #A20, a hospital Pharmacy staff member was requested to provide documentation of the monthly inspection reports for the Advanced Wound Care Center. 3. In interview on the 8-25-14 at 2:20 pm, the staff member indicated there was no documentation of monthly reports for that area and no further documentation was provided prior to exit.		Pharmacy Director providing the Healthy Hearts area nurse manager with the Pharmacy Inspection Report (attached) to complete on a monthly basis. The nurse manager is accountable to complete the Report and fax the completed form to the Pharmacy Director for review and as evidence for the record of the work being completed. 2) This issue was corrected by the Pharmacy Director providing the Advanced Wound Care Center nurse manager with the Pharmacy Inspection Report (attached) to complete on a monthly basis. The nurse manager is accountable to complete the Report and fax the completed form to the Pharmacy Director for review and as evidence for the record of the work being completed.	
S001022	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (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: (B) Appropriate storage conditions.			

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		S001022	1-4. The Director of Pharmacy is the owner and responsible for the correction and the oversight of the medication storage process. The issue was corrected by placing an amber bag around the Octreotide bin. Pharmacy leadership and staff visually inspected other medications in the pharmacy for other medications that were not stored properly with respect to "protect from light". No other deficiencies were found. When new medications are introduced to the formulary a checklist (attached) is used to ensure all pharmacy purchasers know to place these types of medications into protect from light bags. IDR: While we have recognized and corrected this deficiency, we would request that this citation be moved from 410 IAC 15-1.5-2 INFECTION CONTROL to Pharmacy. Per Infection Control Practitioner and Director of Pharmacy the issue is efficacy of the medication and not contamination. Infection Control can't drive the correction process as they are not knowledgeable about what medications are affected by exposure to lighting.	08/28/2014
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			

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	safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 1 piece of equipment. Findings: 1. On 8-25-14 at 10:30 am, employee #A19 was requested to provide documentation of PM on a dishwasher located in the dietary area. 2. In interview, on 8-28-14 at 9:40 am, employee #A19 indicated there was no documentation and none was provided prior to exit.	S001164	The Director of Facilities Engineering is the owner and responsible for ensuring that the routine preventive maintenance is performed on this dietary dishwasher equipment. Correction: The deficiency was corrected as the dishwasher machine had complete and thorough preventive maintenance performed by the manufacturer, Hobart, September 9, 2014. (attached) Future Prevention: A contract (attached) to have routine preventive maintenance performed on a regular basis by the manufacturer was in place as of September 24, 2014.	09/09/2014
S001168	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.			

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	Based on document review, observation and interview, the facility failed to discharge and maintain logs of discharge for 5 of 10 crash cart defibrillators. Findings include: 1. Hospital policy titled "Cardiopulmonary Resuscitation", CLN-2005 Effective date 4/18/14, stated on page 7, #4. Crash Cart, " Daily, Each Crash Cart will be checked one time per staffed shift and during the time period that the department is open. Noted: Departments that are closed and secured for weekends/holidays must perform crash cart check and monitor/defibrillator operational checks when called in for an emergency procedure." "The daily procedural steps in checking of crash cart and in test firing the monitor defib are listed on the log sheet found in eforms and attached to policy." "Documentation of crash cart check will be noted on the Crash Cart Signature Log Sheet." 2. While touring the different units it was noted the crash cart/defibrillator checks were not completed according to policy as follows; a. On 8/25/14 at 10:00 am during the tour of the Emergency Department, for 2 of the 3 defibrillators, the check of the crash cart daily check log for August 2014 indicated no documented checks were	S001168	2a-b. The Director of Intensive Care Units and Critical Care Units who is also Chair of the CHE Safety Leadership Team is the owner and responsible for the Crash Cart management process improvement to ensure compliance with our policy and maintenance of a safe environment for patient care at CHE. We are addressing all clinical units in our process improvement for this citation correction. Process improvement: To complete crash cart checks on every shift per policy. Action plan: 1) Updated crash cart issue to Top 5 Safety Concerns list for CHE, 10/1/14 2) Re-educated managers on the policy and expectations, 10/2/14 3) Managers reviewed Crash Cart logs for sign off checks daily, 10/1/14 4) Managers reviewed expectations with staff, 10/2/14 & ongoing Managers to be trained to perform Crash Cart Audits on 10/15/14 5) Managers begin conducting crash cart content audits biweekly, 10/15/14 & ongoing evaluation according to compliance with policy 6) CHE Patient Care Coordinators education, 10/7 & 10/14 7) Display education at CHE Safety Fair, 10/27/14 8) Educate safety coaches to help monitor & coach peers, 10/27/14 at Safety Coach meeting. 2c. The Director of Maternity Services is the owner and responsible for the	10/27/2014

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	preformed on (M7) 8/2/14 and 8/25/14 and (SR2) 8/7/14. b. on 8/25/14 at 1:25 pm on PICU, the check of the crash cart daily check log indicated no documented checks were preformed on 8/2/14 and 8/25/14. c. On 8/25/14 at 2:10 pm during tour of the Special Care Nursery, the check of the crash cart daily check log indicated no documented checks were performed on 8/14/14. d. On 8/26/12 at 4:45 pm at the Speedway Pavilion Clinic, the check of the crash cart daily check log indicated no documented checks were preformed on 1/2/14, 1/5/14, 1/8/14, 1/9/14, 1/25/14, 1/26/14, 2/8/14, 2/9/14, 2/22/14, 2/23/14, 3/8/14, 3/9/14, 3/22/14, 3/23/14, 4/5/14, 4/6/14, 4/19/14, 44/20/14, 5/3/14, 5/4/14, 5/17/14, 5/18/14,5/26/14, 6/3/14, 6/4/14, 67/14, 6/8/14, 6/14/14, 6/15/14,6/29/14, 7/3/14, 7/4/14, 7/13/14, 7/22/14, 7/23/14,7/25/14, and 7/26/14. 3. Interview with staff member #2 indicated the policy for crash cart checks is followed in the whole hospital system and are to be completed by shift (considered to be either 10 or 8 hours according to the unit) and when open. The Speedway Pavilion Clinic is open daily for one 10 hour shift.		crash cart process improvement for the Special Care Nursery (SCN). The SCN nurse is responsible for the crash cart checks daily and will follow same process as outlined above. A reminder to check the nursery crash cart was added to the Technician's Daily Tech Report as well. (attached) 2d. The Manager of Speedway Medcheck is the owner and responsible for the crash cart/Zoll moniter log process improvement for this off-site facility. Process improvement at this facility will be followed in this action plan: 1) Manager will re-educate staff on policy and expectations, 09/19/2014 and ongoing through the end of December; 2) Manager to review Zoll log (attached) for daily check offs, 09/23 and ongoing weekly for evidence of compliance through the end of December; 3) Management to attend Safety Coach meeting, 10/27/2014 for re-education on Crash carts; 4) Manager to re-evaluate Zoll monitor compliance by staff. If compliance is evident random auditing will be put into place to ensure a safe environment for patients.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 hospital failed to guard against transmission of disease to patients by using the current principles of cross-infection in 2 instances. Findings: 1. On 8-25-14 at 1:50 pm, in the presence of employees #A19 and #A20, it was observed in 2 changing rooms in the Advanced Wound Therapy area, there was considerable dust on the tops of the lockers used by patients. 2. On 8-25-14 at 3:05 pm, in the presence of employees #A19 and #A20, it	S001172	1. The Director of Environmental Services (EVS) is the owner and responsible for the environment being kept clean and orderly in the Advanced Wound Care Center with current principles of cross-infection. Dust was observed in 2 changing rooms on the tops of the lockers used by patients. This issue was fixed immediately upon EVS being told on 8/28/2014. The housekeeper was coached on the Cleaning Specification L - Clinical Suites and Exam Areas requirements (attached). EVS's 90 day plan is that once a week (starting October through the end of December) the evening shift supervisor/director will check the tops of these lockers to ensure	09/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150074	A. BUILDING 00 B. WING	08/28/2014

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	was observed in Room F-1 in the diagnostic radiology area, there was a considerable amount of dust on the top of the fluoroscopy machine.		that they are completely clean. In addition, the evening shift supervisor/director will provide an inspection for this locker room area 4 times per month until there is evidence that this is no longer an issue. Then the inspections will be ongoing random inspections to ensure compliance with current standards of practice. 2. The Director of the Medical Imaging department is the owner and responsible for the diagnostic radiology area being kept clean and orderly including ensuring that the tops of the equipment/machines are free of dust. The dust observed on the fluroscopy machine was corrected same day as cited by the surveyor, 8/25/2014. The technologists are accountable for the actual cleaning of the room area and of the equipment/machines. A cleaning log (attached) has been created for each modality (x-ray, CT, MRI, etc.) and was put into place, 9/15/2014. The Radiology supervisor of each area is accountable for ensuring that the cleaning log is being completed and all items being performed. The log is kept in the control room and will be initialed by the technologist after cleaning is completed. In addition, all technologists have signed the room cleaning process and a copy will be kept in the employees departmental file. Medical Imaging's 90 day plan is	

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			that once a week (starting October through the end of December) the Imaging Director/manager will check the top and back of this fluoscopy unit to ensure that it is completely clean and free of dust. If by the end of December compliance with the cleaning improvement process is in practice then ongoing random inspections of the rooms and equipment will continue to ensure standards of practice in place.	
S001186	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. Based on document review and	S001186	The Manager of the MedCheck	09/19/2014

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	interview, the facility failed to conduct fire drills in accordance with facility policy in 1 instance. Findings: 1. Review of hospital policy ADM: F-002B, entitled HOSPITAL LICENSED OUTPATIENT FIRE RESPONSE PLAN, reviewed 09/09/13, indicated all ambulatory and state board of Hospital Outpatient Facilities will conduct a fire drill once per quarter, per shift. 2. Review of fire drills conducted at 4 offsite facilities for calendar year 2013, indicated at the Community Med Check - Speedway facility, there was no fire drill conducted in the 3rd quarter. 3. In interview, on 8-28-14 at 10:15 am, employee #A22 confirmed the above and no further documentation was provided prior to exit.		Speedway is the owner and responsible for ensuring the fire drills are conducted according to facility policy. Plan of correction: 09/19/2014 Staff meeting completed and told of policy of quarterly fire drill completion necessity. Fire drill completed with staff and management working that day. (attached) Fire drills per policy are to be conducted once per quarter, with the months being March, June, September and December. The fire drills have been added to management outlook calendar as a reminder, along with posting of the requirements for all of staff to review. An inservice was provide at the 09/19/2014 staff meeting. Policy regarding fire and disaster drills was reviewed with all staff and management team. To ensure that the deficient practice will not reoccur, as stated above, drill dates have been added to the outlook calendar to allow sufficient time for drills to be completed prior to due dates. Monitoring will include: 1) The manager as the owner and responsible party 2) System for monitoring shall be done via outlook calendar, and memo posting 3) Will do drills with quarterly staff meetings 4) Monitoring will be ongoing as stated	