

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150056	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46206
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005051</p> <p>Survey Date: 11-26/29-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>Billie Jo Fritch, RN Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Linda Dubak, RN Public Health Nurse Surveyor</p>	S0000	<p><b>DISCLAIMER</b> Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the IU Health of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. <b>Credible Allegation of Compliance and Correction:</b> For the purpose of any allegation that IU Health is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health's credible allegation of correction and compliance.</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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	Ken Ziegler Medical Surveyor  QA: cloughlin 12/11/12			

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, document review and interview, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients for 1 offsite and 5 of 13 units toured.</p> <p>Findings include:</p> <p>1. On 11-27-12 at 0940 hours in the company of staff #4, a housekeeper was observed pulling a housekeeping cart out of room A1409 at the Saxony campus, which was labeled as a soiled utility room. The housekeeper was observed to start cleaning areas in the department with items on the cleaning cart.</p> <p>2. On 11-27-12 at 0950 hours, staff #47 confirmed that housekeeping carts are stored in room A1409 and the carts stored in room A1409 are used to clean the Cardiac Cath Procedure rooms.</p>	S0554	<p><b>Tag S554 Rule #</b> <b>410IAC15-1.5-2(a) Findings:</b> An environmental services cart was stored in a soiled utility room and used to clean the ED and Cath Lab. <b>Corrective Action:</b></p> <p>1. The cart was properly stored immediately.</p> <p>2. Department staff were retrained by December 28, 2012.</p> <p><b>Monitoring:</b> Periodic observations will be conducted to assure appropriate separation and storage. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur <b>Responsible Persons:</b> Director of Environmental Services or designee <b>Completion Date:</b> 12/28/2012 <b>Tag S554 Rule #</b> <b>410IAC15-1.5-2(a) Findings:</b> Tech spiking IV bags over sink with tube dangling in the sink and over the faucet. <b>Corrective Action:</b> The procedure was clarified with all department staff by December 20, 2012 to assure work is performed in the appropriate work area using aseptic technique. <b>Monitoring:</b> Periodic random observations will</p>	01/31/2013			

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			<p>take place to assure appropriate procedures are followed. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur.</p> <p><b>Responsible Persons:</b> Director of Peri-operative Services or designee <b>Completion Date:</b> 12-20-2012 <b>Tag S554 Rule # 410IAC15-1.5-2(a) Findings:</b> A canvas bin used to store waste had three sharps containers and was uncovered and unmonitored.</p> <p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>The bin was covered and moved to a location where it could be monitored until disposal took place.</li> <li>Department staff were retrained by December 28, 2012.</li> </ol> <p><b>Monitoring:</b> Periodic random observations will take place to assure proper containment and storage. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur.</p> <p><b>Responsible Persons:</b> Director of Environmental Services or designee <b>Completion Date:</b> 12-28-2012 <b>Tag S554 Rule # 410IAC15-1.5-2(a) Findings:</b> Linens remain in the room during the stays of more than one patient.</p> <p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>Linens were removed immediately.</li> <li>Department staff were retrained by December 28, 2012.</li> </ol>		

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			<p><b>Monitoring:</b> Periodic random observations will take place to assure linens are removed at discharge. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Director of Environmental Services or designee <b>Completion Date:</b> 12-28-2012 <b>Tag S554 Rule # 410IAC15-1.5-2(a) Findings:</b> The room had been cleaned but the over bed table had debris inside indicating it had not been cleaned. <b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>1.The over bed table was immediately cleaned.</li> <li>2.Department staff were retrained by December 28, 2012 on including the overbed table n cleaning</li> </ol> <p><b>Monitoring:</b> Periodic random observations will take place to assure cleaning takes place. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Director of Environmental Services or designee <b>Completion Date:</b> 12-28-2012 <b>Tag S554 Rule # 410IAC15-1.5-2(a) Findings:</b> Staff indicated they left Sani-master to dry for 5-10 minutes. <b>Corrective Action:</b> 1. All environmental services staff underwent retraining by December 28, 2012 on proper dry</p>		

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	<p>3. Facility policy titled 'DISCHARGE/TRANSFER CLEANING' last reviewed/revised 4/16/12 states on page 1, under "Sanitize and spot clean"....."Check the patient's closet, overbed table....."</p> <p>4. The label instructions for Sani master 4 indicated the surface must remain wet with the product for a period of 10 minutes to be effective against all organisms.</p> <p>5. During tour of the surgery department beginning at 10:05 a.m. on 11/26/12 and accompanied by staff member #N2, tech #1 was observed spiking IV solutions to</p>		<p>times. 2. Nursing staff will undergo retraining during staff meetings in January, 2013 on proper dry times. 3. Posters showing dry times for all cleaning products were posted by January 4, 2013 in nursing units.</p> <p><b>Monitoring:</b> Periodic random observations will take place to assure appropriate dry times are observed. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Chief Nursing Executive and Director of Environmental Services or designees <b>Completion Date:</b> 1-31-2013</p>	

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	<p>be used for surgery patients over a handwashing sink with the tubing dangling in the sink and draped over the faucet of the sink.</p> <p>6. During tour of the emergency department (ED) beginning at 11:30 on 11/26/12 and accompanied by staff members #N1 and N2, a canvas bin was sitting in the public hall outside the ED doors under a sign indicating it was a "waste wagon". The canvas bin was unmonitored, uncovered and contained 3 sharps containers which posed a risk to visitors if the sharps containers were removed from the bin.</p> <p>7. During tour of the short stay unit beginning at 12:05 p.m. on 11/26/12 and accompanied by staff members #N1 and N2, linens were observed in a room that had been cleaned and ready for a patient admission.</p> <p>8. During tour of the oncology unit beginning at 1:40 p.m. on 11/26/12 and accompanied by staff members #N1 and N2, an overbed table in room 5134, which was cleaned and ready for a patient admission, had soiled popsicle sticks, a plastic knife, a metal knife, a crayon and dried food debris inside the compartments under the table top.</p>						

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	<p>9. #H1 indicated in interview in the newborn intensive care unit beginning at 11:00 a.m. on 11/27/12 that he/she uses Sani master 4 for cleaning the admission carts between patients and leaves the solution on the surface for 5-10 minutes.</p> <p>10. PSA #1 indicated in interview at 12:15 p.m. on 11/26/12 that the linens that are not used by a patient on the short stay unit are left in the patient room after discharge.</p>			

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S0556	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(b)</p> <p>(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 of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to follow the facility policy requiring documentation of immunity to Varicella for 2 of 3 (V#34 and V#37) dietary personnel hired after July 2011.</p> <p>Findings included:</p> <p>1. Review of personnel files on 11-29-12 lacked evidence that 2 of 3 (V#34 and V#37) dietary personnel, hired 6-14-12 and 2-13-12 respectively, had documented proof of Varicella immunity as required by facility policy (revised July 2011).</p> <p>2. Review of facility policy titled PRE-PLACEMENT HEALTH ASSESSMENT (revised July 2011) on 11-29-12 indicated the following: Varicella (Chicken Pox): At the time of pre-placement health assessment, the Varicella immune status of candidates</p>	S0556	<p><b>Tag S 556 Rule # 410 IAC 15-1.5-2(b) Findings:</b> Two personnel hired 6/14/12 AND 2/13/12 did not have proof of Varicella immunity as required by policy revised July 2011.</p> <p><b>Corrective Action:</b></p> <p>1.The hospital confirmed by December 1, 2012 that one of the two employees received vaccination at hire. It is now reflected in the employee's file.</p> <p>2.The second employee obtained vaccination by December 28, 2012.</p> <p><b>Monitoring:</b> Beginning December 1, 2012, the Staff Resources Coordinator will verify that all new hires have received appropriate vaccination before beginning work. The immediate supervisor will assure the employee visits Employee and Occupational Health to receive appropriate vaccination before beginning work.<b>Responsible Persons:</b> Director of Food Services or designee</p> <p><b>Completion Date:</b> 12-28-2012</p>	12/28/2012			

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	<p>shall be determined. Immunity to Varicella is a condition of employment. Candidates will be considered immune to Varicella if they have documentation of health-care provider diagnosis of Varicella or Herpes Zoster, laboratory evidence of immunity to Varicella, or 2 Varicella vaccines of at least 4-8 weeks apart. If candidate does not have documentation of immunity then draw Varicella titer at no charge to the candidate. If candidates Varicella titer in (known misspelling) non-reactive, EOHS will administer the Varicella vaccine, two doses 28 days apart, at no charge. Candidates who are non-immune and refuse the vaccine for medical reasons will need to obtain documentation from their physician explaining their medical contraindication to the vaccine. Candidates who are non-immune and refuse the vaccine for reasons other than physician documented medical contraindication to the vaccine will be informed that they are ineligible for hire.</p> <p>3. Interview with B#6 on 11-29-12 confirmed that 2 of 3 (V#34 and V#37) dietary personnel, hired 6-14-12 and 2-13-12 respectively, lacked documented proof of Varicella immunity as required by facility policy (revised July 2011).</p>				

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S0596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation and interview, the infection control committee failed to ensure the pre-operative assessment patient care area was cleaned and disinfected according to acceptable standards of practice.</p> <p>Findings included:</p> <p>1. During the tour of the pre-operative assessment area at 9:25 AM on 11/28/12, accompanied by staff members #SN10, SN22, and SN24, the wall suction canisters and ledges in the individual patient rooms were observed with a layer of dust. The bottoms of the patient carts/beds were also observed with a heavy layer of dust.</p>	S0596	<p><b>Tag S 596 Rule # 410 IAC 15-1.5-2(f)(3)(D)(iii) Findings:</b> Wall suction canisters and ledges in patient rooms had a layer of dust. The bottoms of patient carts/beds had a heavy layer of dust. Carts are pushed into the operating room when patients are transported to and from surgery. <b>Corrective Action:</b> 1. Wall canisters, ledges, and bottoms of carts were cleaned by November 29, 2012. They are now included in routine daily cleaning. 2. The bottom of carts will be cleaned at least monthly by peri-operative staff. <b>Monitoring:</b> Peri-operative managers will assure monthly cleaning takes place. <b>Responsible Persons:</b> Directors of Environmental Services and Peri-Operative Services <b>Completion Date:</b> 12-28-2012</p>	12/28/2012			

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	<p>2. At 9:30 AM on 11/28/12, staff member #SN24 indicated the area was hard to keep free of dust, but the environmental services staff was responsible for the wall areas in the rooms. He/she indicated the nursing staff cleaned the patient carts, but only oxygen tanks were kept on the bottoms of the carts. When questioned, he/she confirmed the carts/beds were pushed into the operating suites when the patients were transported to and from surgery.</p> <p>3. At 9:45 AM on 11/28/12, staff member #SN25, a nurse working this unit, indicated he/she personally didn't clean the carts, but it was usually done by the Patient Care Techs (PCTs).</p> <p>4. At 9:50 AM on 11/28/12, staff member #SN26, a PCT working this unit, described cleaning the mattress, siderails, and top frame/handles of the carts/beds with the sanitizing wipes. When questioned about the bottoms and wheels, he/she indicated he/she did not clean those areas.</p>			

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S0610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation, document review and interview, the facility failed to ensure high-protein enteral tube-feeding supplements were stored according to manufacturer label in the formula room and failed to ensure temperatures in the refrigerators in the patient rooms on the 9E surgical trauma unit and for a refrigerator located in the Riley speech department were monitored.</p>	S0610	<p><b>Tag S 610 Rule # 410 IAC 15-1.5-2(f)(3)(D)(x) Findings:</b> The hospital failed to ensure high protein enteral tube-feeding supplements were stored according to manufacturer label in the formula room. <b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>1.Improperly stored supplements were discarded immediately.</li> <li>2.Kitchen and pantry areas and</li> </ol>	01/28/2013

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	<p>Findings included:</p> <p>1. At 3:00 PM on 11/26/2012, it was observed in the formula room that 502 enteral feeding supplements were stored on the shelves outside the cartons they were shipped in. The ready-to-feed nutrient supplies were exposed to the department's ceiling mounted fluorescent light fixtures. The department contained the following items stored outside their shipping cartons: 182 of bottles Similac Special Care 30 Kcal/oz, 2 ounce; 192 bottles of Similac Special Care 24 Kcal/oz, 2 ounces; 108 bottles of Similac Special Care High Protein 24 Kcal/oz, 2 ounces; 4 bottles of Enfamil Premature 24 Kcal/oz, 2 ounces; and 16 bottles of Similac Special Care 20 Kcal/oz, 2 ounces.</p> <p>2. The manufacturer's label on the assorted enteral ready-to-eat nutritional supplements indicated the bottles contain light sensitive nutrients. The manufacturer requires the items to be stored in a cabinet, amber or dark container, or within the carton they are shipped.</p>		<p>supply chain storage locations were assessed to ensure all supplements were properly stored by January 4, 2012.</p> <p>3.A revised procedure was implemented November 27, 2012 to store supplements in shipping containers until black and gray plastic storage boxes designed to block all light are received.</p> <p><b>Monitoring:</b> Proper storage is being monitored on an ongoing basis by area managers. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur.</p> <p><b>Responsible Persons:</b> Chief Nursing Executive and Director of Supply Chain Services</p> <p><b>Completion Date:</b> 12-28-2012</p> <p><b>Tag S 610 Rule # 410 IAC 15-1.5-2(f)(3)(D)(x) Findings:</b> Patient rooms on the 9E surgical trauma unit had no refrigerator/freezer temperature monitoring per hospital policy</p> <p><b>Corrective Action:</b></p> <p>1.Policy was revised to clarify that refrigerators not used to store patient food do not require temperature monitoring.</p> <p>2.Environmental Services staff will apply signage by January 28, 2013 to refrigerators indicating they are for family convenience.</p> <p><b>Monitoring:</b> Not required.</p> <p><b>Responsible</b> Chief Nursing Executive and Director of Environmental Services or designees <b>Completion Date:</b> 1-28-2013 <b>Tag S 610 Rule # 410</b></p>		

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	3. Facility policy titled "REFRIGERATOR AND FREEZER TEMPERATURE MONITORING" last reviewed/revised 5/12 states on page 2: "C. The temperature of each refrigerator and each freezer used to store food, or specimens in patient care areas will be monitored and documented daily when open for business for acceptable temperature ranges." Under procedures, the policy states on page 2: "Temperature Monitoring 1. Manual temperature monitoring: a. All refrigerators and freezers must contain a thermometer in each section. b. Check refrigerator and freezer temperature daily, record on the log....."		<b>IAC 15-1.5-2(f)(3)(D)(x)</b> <b>Findings:</b> Refrigerator in Riley Speech Department not monitored in October. <b>Corrective Action:</b> Monitoring has taken place daily since the deficiency was noted during the tour.. <b>Monitoring:</b> Periodic random observations will take place to assure proper monitoring occurs. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Director of Speech Disorders Clinic <b>Completion Date:</b> 12-28-2012		

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	<p>4. During tour of the trauma surgery unit (9E) beginning at 1:15 p.m. on 11/26/12 and accompanied by staff members #N1 and N2, refrigerators were provided in the patient rooms and had no temperature monitoring per policy.</p> <p>5. Staff member #RN03 indicated in interview at 1:30 p.m. on 11/26/12 that the temperatures in the refrigerators in the patient rooms on the 9E surgical trauma unit are not monitored.</p> <p>6. Review of a document entitled DAILY REFRIGERATOR/FREEZER TEMPERATURE LOG, for a refrigerator located in the Riley speech department, indicated there were no entries indicating the temperature had been checked for the time periods in 2012 of September 17-21, September 24-28 and November 1, 2012 through November 26, 2012.</p> <p>7. In interview, hospital staff indicated the form was to be completed each day the department was open, and that there was no documentation for the month of October, 2012. No further documentation was provided prior to exit.</p>						

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S0744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on document review and staff interview, the facility failed to ensure medical records were complete for 2 (#N16, #N18) of 3 patients transferred to another acute care facility.</p> <p>Findings include;;</p> <p>1. Facility policy titled "PATIENT TRANSFER TO ANOTHER FACILITY" last reviewed/revised 7/11 states on page 2 of 4: "B. Criteria for Transfer to Another Facility.....b..... The signed certification must include a summary of the risks and benefits upon which the decision to transfer is based..." and "C. Procedure for "Appropriate" Transfer....3. Copies of all the current medical records are made and sent with the patient to the receiving facility. 4. Nursing report should be called to the receiving institution. ....6. Complete the transfer form."</p> <p>2. Review of patient #N16 medical record indicated the following: (A) Facility document titled "REQUEST</p>	S0744	<p><b>Tag S 744 Rule # 410 IAC 25-2.5-4(e)(1) Findings:</b> Sections of the form were blank on the first patient; the second patient's form was blank at benefits of transfer. <b>Corrective Action:</b> 1. The Integrated Care Management Department staff were reeducated on expectations that the form is completed by January 2, 2013.2. The Integrated Care Management Department developed and implemented an audit tool January 2, 2013. <b>Monitoring:</b> 100% of the charts of discharged patients who are not discharged to home care or self care will be audited for the first quarter of 2013 to ensure compliance of at least 90%. If performance gaps are identified, steps will be taken to assure staff complete documentation. A weekly summary will be provided to Department and Executive Directors to assure forms are complete. <b>Responsible Persons:</b> Director of the Department of Integrated Care Management <b>Completion Date:</b> 1-2-2013</p>	01/02/2013

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	<p>FOR FACILITY TRANSFER" lacked documentation that nursing report was called, copies of the current medical record were made and sent, mode of transport was marked, the time of the transfer was listed and the nurse signed the form. The sections listed were left blank on the form.</p> <p>3. Review of patient #N18 medical record indicated the following: (A) The patient was transferred to another acute care facility on 9/13/12. (B) Facility document titled "REQUEST FOR FACILITY TRANSFER" lacked documentation of benefits of the transfer. This section of the form was left blank.</p> <p>4. Staff member #MR2 verified the above at 3:00 p.m. on 11/28/12.</p>				

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S0812	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5 (a)(4)(A)(B)(C)(D)(E)(F)(G)(H)(I)(J)(K)</p> <p>(a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following:</p> <p>(4) Maintain a file for each member of the medical staff that includes, but is not limited to, the following:</p> <p>(A) A completed, signed application. (B) The date and year of completion all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A copy of the member's current Indiana license showing the date of licensure and current number or an available certified list provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the medical licensing board. (D) A copy of the member's current Indiana controlled substance registration showing the number, as applicable. (E) A copy of the member's current Drug Enforcement Agency registration showing the number, as applicable (F) Documentation of experience in the practice of medicine.</p>			

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	<p>(G) Documentation of specialty board certification, as applicable.</p> <p>(H) Category of medical staff appointment and delineation of privileges approved.</p> <p>(I) A signed statement to abide by the rules of the hospital.</p> <p>(J) Documentation of current health status as established by hospital and medical staff policy and procedure and federal and state requirements.</p> <p>(K) Other items specified by the hospital and medical staff.</p> <p>Based on document review and interview, the facility failed to ensure that allied health practitioners were performing the privileges that each was approved to perform for 3 of 3 allied health files reviewed (Staff #11, 12 &amp; 13).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 11-27-12 at 1045 hours, staff #68 confirmed that staff #11 performs harvesting veins on patients for open heart surgery.</li> <li>On 11-28-12 at 1145 hours, staff #67 confirmed that staff #12 &amp; 13 perform harvesting veins on patients for open heart surgery.</li> <li>Review of staff #11, 12 &amp; 13's privileging files indicated lack of documentation of being granted privileges to harvest veins.</li> </ol>	S0812	<p><b>Tag S 812 Rule # 420 IAC 1 5-1.5-5-5(H) Findings:</b> The hospital failed to ensure that allied health practitioners were performing the privileges that each was approved to perform for 3 of 3 allied health files reviewed.</p> <p><b>Corrective Action:</b> Vein harvesting privileges were added to the privilege form. Criteria for granting privileges were developed and approved by the Medical Staff Executive Committee. The Board of Directors granted privileges for vein harvesting on December 18, 2012. <b>Monitoring:</b> Advanced practitioners will be required to request vein harvesting privileges. Verification of education and training will take place before privileges are granted or before nurses and technicians are allowed to perform first assistant job duties. Periodic, ongoing review takes place to assure that practitioners are performing only procedures for which they have</p>	12/18/2012

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	4. On 11-29-12 at 1430 hours, staff #61 confirmed that the current privileging request forms for staff #12 & 13 lacked documentation of the privilege to harvest veins.		privileges. <b>Responsible Persons:</b> Medical Staff Executive Committee and Board of Directors <b>Completion Date:</b> 12-18-2012		

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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(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:</p> <p>(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 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.</p> <p>Based on policy and procedure review, medical record review, and interview, the nurse executive failed to follow established policy/procedures of nursing practice for admitting patients for 6 of 12</p>	S0912	<p><b>Tag S 912 Rule # 410 IAC 15-1.5-6(a)(2)(B)(i-vi) Findings:</b> Nursing admission assessment was not complete <b>Corrective Action:</b> 1.A standardized training tool</p>	01/31/2013

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	<p>inpatient medical records (MR) reviewed (Patient #7, 14, 16, 17, 18 and 19) and failed to ensure the facility's policy for restraints was followed for 4 of 4 patients who had restraints applied during their hospitalization (#S1, S3, S5, and S7).</p> <p>Findings include:</p> <p>1. Review of policy/procedure NADM 1.30AP, Documentation Standards: Inpatient, indicated the following: "7. Admission History a. Within 24 hours of admission, the nurse will complete all required fields on the admission history including the patient health history." This policy/procedure was last reviewed/revised on 10-12.</p> <p>2. Review of patient #7, 14, 16, 17, 18 and 19's MR indicated that each MR had areas such as cardiovascular, endocrine metabolic, musculoskeletal etc., identified as Yes for having positive history and each lacked documentation of what the positive history was.</p> <p>3. On 11-29-12 at 1105 hours, staff #65 confirmed the nursing admission health histories for #7, 14, 16, 17, 18 and 19 were not complete.</p> <p>4. The facility's policy "Use of Restraints</p>		<p>was provided to managers by January 4, 2013.</p> <p>2. Staff will receive training on completion of the admission assessment during staff meetings in January, 2013.</p> <p><b>Monitoring:</b> Periodic random observations will take place to assure completed admission assessments. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur <b>Responsible Persons:</b> Chief Nursing Executive or designee <b>Completion Date:</b> 1-31-2013 <b>Tag S 912 Rule # 410 IAC 15-1.5-6(a)(2)(B)(i-vi) Findings:</b> Restraint documentation was incomplete. <b>Corrective Action:</b> 1. A standardized training tool was provided to managers by January 4, 2013. 2. Staff will receive retraining on restraint documentation during staff meetings in January, 2013. <b>Monitoring:</b> Periodic random observations will take place to assure proper restraint documentation. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Chief Nursing Executive or designee <b>Completion Date:</b> 1-4-2013</p>				

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	<p>and Seclusion", effective June 2010, indicated, "B. Use of Physical Restraints for Non-Violent Behavior: ...2. Obtain/Provide a Restraint Order, a. A non-violent restraint order must be obtained from a LIP [licensed independent practitioner] prior to or within 4 hours of applying restraints. ...f. Non-violent restraint orders require renewal every 24 hours. g. Once restraints are removed from the patient as part of discontinuing their use, a new order must be obtained if restraint use is again warranted. ...4. On-going Monitoring: ...On-going monitoring is documented a minimum of every two (2) hours. ...5. Discontinue the restraints at the earliest possible time while allowing for continued safety for the patients. Document when the restraints are removed."</p> <p>5. The medical record for patient #S1 indicated a problem of "Restraints" listed on the individualized care plan from 1441 on 10/01/12 through 0800 on 10/11/12, but only every 2 hour monitoring from 0800 on 10/05/12 through 1000 on 10/06/12. The record indicated physician's orders for the restraints from 1113 on 10/05/12 and 0820 on 10/06/12. The record lacked documentation of the restraints being discontinued until a notation at 2000 on 10/06/12, "Restraints</p>			

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	<p>discontinued per previous shift when patient extubated. 10/06/2012 11:30."</p> <p>6. The medical record for patient #S3 indicated a problem of "Restraints" listed on the individualized care plan from 10/07/12 through 10/19/12, but only every 2 hour monitoring through 0423 on 10/17/12. The record lacked physician renewal orders for 10/08/12 and 10/11/12 for the use of restraints. The record also lacked documentation of discontinuing the restraints.</p> <p>7. The medical record for patient #S5 indicated restraints were initiated at 2000 on 10/02/12 and continued through 10/09/12, but lacked physician renewal orders from 10/03/12, 10/06/12, and 10/08/12. The record lacked every 2 hour monitoring between 1600 on 10/05/12 through 1200 on 10/06/12 with no explanation or discontinuation information.</p> <p>8. The medical record for patient #S7 indicated a lack of 2 hour restraint monitoring between 1000 on 11/26/12 through 0100 on 11/27/12, but the monitoring continued through 1400 on 11/28/12. The record lacked any explanation or discontinuation information.</p>						

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	9. At 11:45 AM on 11/29/12, staff member #SN5, who was navigating the Electronic Medical Record (EMR), confirmed the discrepancies with the restraint orders and monitoring documentation.			

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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on document review and staff interview, the facility failed to ensure a registered nurse followed physician orders for 5 of 19 pediatric medical records reviewed and 2 of 5 death records reviewed.</p> <p>Findings include:</p> <p>1. Review of patient #N5 medical record indicated the following: (A) An order was written on 11/25/12 to call if the dystolic blood pressure (DBP) was &lt; 65 or the patients respirations were above 25. (B) The medical record indicated that the patients DBP was 57 at 8:00 a.m. on 11/26/12 and the patients respiratory rate was 28 at 12:00 noon on 11/26/12. (C) The medical record lacked evidence that the abnormalities were reported to the physician per order.</p> <p>2. Review of patient #N7 medical record indicated the following: (A) An order was written on 11/23/12 to</p>	S0930	<p><b>Tag S 930 Rule # 410 IAC 15-1.5-6(b)(4) Findings:</b> Orders were not carried out as ordered for monitoring and for changing a PICC leur lock cap; and abnormalities were not reported to the physician. <b>Corrective Action:</b></p> <p>1.A standardized training tool was provided to managers by January 4, 2013. 2.Staff will receive retraining on documenting physician order implementation during staff meetings in January, 2013. <b>Monitoring:</b> Periodic random observations will take place to assure orders are carried out and abnormalities are reported to the physician. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Chief Nursing Executive or designee <b>Completion Date:</b> 1-31-2013</p>	01/31/2013			

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	<p>check vital signs every 4 hours to include B/P, pulse, and respirations.</p> <p>(B) The medical record lacked evidence that the vital signs were taken every 4 hours per order including, but not limited to, no pulse rate checked from 2:00 p.m. 11/24/12 until 11:00 p.m. on 11/24/12 and no blood pressure check from 11/23/12 at 10:00 p.m. until 11/27/12 at 9:00 a.m..</p> <p>3. Review of patient #N11 medical record indicated the following: (A) An order was written on 10/8/12 to assess the patients sedation level every 2 hours while on a PCA pump providing pain medication. (B) The patients sedation level was checked every 4 hours instead of every 2 hours as per order.</p> <p>4. Review of patient #N14 medical record indicated the following: (A) An order was written on 10/9/12 to weigh the patient every Monday, Wednesday, and Friday. (B) The patient was not weighed on 10/10/12 (Monday).</p> <p>5. Review of patient #N22 medical record indicated the following: (A) An order was written on 10/5/12 to change the luer lock cap on the PICC line every 96 hours.</p>				

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	<p>(B) The cap was due to be changed on 10/9/12. The medical record lacked evidence that the cap was changed.</p> <p>6. Review of patient #N26 medical record indicated the following: (A) An order was written on 9/7/12 to call physician if the patients temperature was above 101.5 or the systolic blood pressure (SBP) was &lt; 90. (B) The patients blood pressure was 68/49 at 4:00 p.m. on 9/17/12 and the patients temperature was 102.9 at 10:00 p.m. on 9/17/12. (C) The medical record lacked evidence that the abnormalities were reported to the physician per order.</p> <p>7. Review of patient #N30 medical record indicated the following: (A) An order was written on 8/22/12 to change the luer cap on the PICC line every 96 hours. The cap was due to be changed on 9/6/12. The medical record lacked evidence that it was changed per order.</p> <p>8. RN#001 verified findings in patient #N5 medical record at 3:15 p.m. on 11/26/12.</p> <p>9. RN #02 verified findings in patient #N7 medical record at 9:45 a.m. on 11/27/12.</p>						

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	<p>10. Staff member #MR1 verified findings in patient #N11 medical record at 12:10 p.m. on 11/28/12.</p> <p>11. Staff member #MR2 verified findings in patient #N14 and #N22 medical records at 3:00 p.m. on 11/28/12 and the findings in patient #N26 medical record at 10:00 a.m. on 11/29/12.</p> <p>12. Staff member #MR3 verified findings in patient #N30 medical record at 1:00 p.m. on 11/29/12.</p>						

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S0932	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on policy and procedure review, medical record review, and interview, the nursing staff failed to ensure care plans were updated per policy for 4 of 5 death records reviewed and failed to follow their policy regarding individualized care planning for restraints for 3 of 4 patients who experienced the use of restraints during their hospitalizations (#S1, S3, and S7).</p> <p>Findings include:</p> <p>1. Facility policy titled "DOCUMENTATION STANDARDS: INPATIENT" last reviewed/revised 11/11 states on page 11 of 15 under "Plan of Care": "During each shift, the nurse will review the current care plans initiated and revised them as needed based on the patient's situation. b. If new problems are identified, initiate any relevant care plans selecting appropriate goals, intervention, and orders.....e.</p>	S0932	<p><b>Tag S 932 Rule # 410 IAC 15-1.5-6(b)(4) Findings:</b> Facility policy calls for the plan of care to be initiated and revised during each shift. <b>Corrective Action:</b></p> <p>1.A standardized training tool was provided to managers by January 4, 2013.</p> <p>2.Staff will receive retraining on plans of care documentation during staff meetings in January, 2013.</p> <p><b>Monitoring:</b> Periodic random observations will take place to assure the plan of care is initiated and revised each shift. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur.</p> <p><b>Responsible Persons:</b> Chief Nursing Executive or designee</p> <p><b>Completion Date:</b> 1-31-2013</p>	01/31/2013

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	<p>Include restraints/seclusion if intervention is implemented."</p> <p>2. Review of patient #N25, N26, N29, and N30 medical records indicated the following: (A) The condition of the patients deteriorated and they were made a "do not resuscitate" (B) The care plans were not updated to reflect that the patients were dying. Discharge planning was part of the care plan and the plan included, but was not limited to, educational materials given and discharge instructions given.</p> <p>3. Staff member #MR2 verified the medical record documentation for patients #N25 and N26 at 10:00 a.m. on 11/29/12.</p> <p>4. Staff member #MR3 verified the medical record documentation for patients N29 and N30 at 1:00 p.m. on 11/29/12.</p> <p>5. The facility policy "Documentation Standards: Inpatient", effective October 2012, indicated, "14. Plan of Care: ...c. For all accepted plans, the nurse will define the plan by selecting appropriate goals, interventions, and orders. d. Identify a minimum of one daily goal per problem. e. Include restraints/seclusion if intervention is implemented. ...17. Plan of Care: a. During each shift, the nurse</p>				

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	<p>will review the current care plans initiated and revise them as needed based on the patient's situation. ...c. Document any nursing interventions completed. d. The nurse will mark all goals as met or not met. For goals that are not met, a reason for the variance should be documented."</p> <p>6. The medical record for patient #S1 indicated a problem of "Restraints" on the care plan from 1441 on 10/04/12 through 0800 on 10/11/12, but lacked any interventions or goals for the problem. Also, according to the monitoring record and physician orders, the patient only actually had restraints from 0800 on 10/05/12 through 1000 on 10/06/12.</p> <p>7. The medical record for patient #S3 indicated a problem of "Restraints" on the care plan from 10/07/12 through 10/19/12, but lacked any interventions or goals for the problem. Also, according to the monitoring record and physician orders, the patient only actually had restraints from 10/07/12 through 10/17/12.</p> <p>8. The medical record for patient #S7 indicated restraints were initiated an midnight on 11/22/12, but the care plan lacked documentation of "Restraints" as a problem with interventions and goals.</p>			

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	9. At 11:45 AM on 11/29/12, staff member #SN5, who was navigating the Electronic Medical Record (EMR), confirmed the lack of documentation on the care plans according to policy.			

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S0936	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(6)</p> <p>(b) The nursing service shall have the following:</p> <p>(6) All nursing personnel shall demonstrate and document competency in fulfilling assigned responsibilities. Based on document review and interview the facility failed to ensure that all nursing personnel demonstrate and document competency in fulfilling assigned responsibilities for 5 of 10 Saxony Campus personnel files reviewed (Staff #2, 3, 7, 9 and 10).</p> <p>Findings include:</p> <p>1. Review of policy/procedure HR-142, Orientation, indicated the following: "E. Department Orientation 1. Each department provides a defined orientation for their new employees. 3. A completed department orientation document for each employee is maintained in the employee's regulatory file." This policy/procedure was last reviewed/revised on 10-2012.</p> <p>2. Review of staff #2, 3, 7, 9 and 10's personnel file indicated lack of documentation of a department orientation.</p>	S0936	<p><b>Tag S 936 Rule # 410 IAC 15-1.5-6(b)(6) Findings:</b> Competency was not documented in 5 of 10 Saxony personnel files. <b>Corrective Action:</b> Competency documentation was located after the survey and placed in personnel files. <b>Monitoring:</b> Monitoring will take place over the first quarter of 2013 to ensure that files contain required competencies. <b>Responsible Persons:</b> Saxony Hospital Chief Nursing Officer or designee <b>Completion Date:</b> 12-15-2012</p>	12/15/2012			

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	3. On 11-29-12 at 1335 hours, staff #66 confirmed that #2, 3, 7, 9 and 10's personnel file lacked documentation of a department orientation.			

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on Policy/Procedure review, transfusion record review, and staff interview the facility failed to follow an approved medical staff Policy/Procedure for the administration of transfusions in 18 of 28 transfusions reviewed.</p> <p>Findings included: 1. On 11/26/12 between 4:00 p.m. and 4:30 p.m. review of Policy #: HM 1.01AP, Effective date: June 2012 supplied by staff person #10 revealed: "VI. PROCEDURES B. 1. Pre-transfusion Vital Signs: record vital signs prior to transfusion initiation." 2. On 11/29/12 between 10:00 a.m. and 2:00 p.m. review of transfusion records revealed:</p> <table border="1"> <thead> <tr> <th>Transfusion Number</th> <th>Pre Vital Time</th> <th>Transfusion Start time</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>1035</td> <td>1035</td> </tr> <tr> <td>2</td> <td>0235</td> <td>0235</td> </tr> <tr> <td>3</td> <td>1645</td> <td>1645*</td> </tr> </tbody> </table>			Transfusion Number	Pre Vital Time	Transfusion Start time	1	1035	1035	2	0235	0235	3	1645	1645*	S0952	<p><b>Tag S 952 Rule # 410 IAC 15-1.5-6(d) Findings:</b> The facility failed to follow an approved medical staff policy/procedure for administration of transfusions in 18 of 28 transfusions reviewed <b>Corrective Action:</b> 1.The Transfusion Administration Policy was revised to state that pre-transfusion vital signs must be completed within 60 minutes prior to transfusion initiation. 2.The clarification was communicated to nursing staff on 1/4/13 <b>Monitoring:</b> Chart audit will take place for the first two quarters of 2013 to assure documentation compliance of at least 90%. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Chief Nursing Executive or designee <b>Completion Date:</b> 1-4-2013</p>		01/04/2013
Transfusion Number	Pre Vital Time	Transfusion Start time																	
1	1035	1035																	
2	0235	0235																	
3	1645	1645*																	

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4	0940 0940			
5	0400 0400			
25	1724 1724			
7	0420 0420			
8	2320 2320			
10	2330 2330			
11	0041 0041			
12	1320 1320			
26	2100 2100			
13	0030 0030			
14	0900 0900			
15	0800 0800			
16	1555 1555			
18	0450 0450			
22	1415 1415 where the Pre-transfusion Vital Signs were taken as the transfusions were initiated and not prior to transfusion initiation. Transfusion #3 also had the above listed start time which is not correct as that unit of blood was not dispensed until 1813. 3. In interview on 11/29/12 between 1:30 p.m. and 2:00 p.m. staff person #10cp acknowledged the above data was as listed.			

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S1028	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(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, interview and document review, the hospital failed to secure access to 1 drug storage area within the hospital.</p> <p>Findings:</p> <p>1. On 11-28-12 at 9:50 am, in the presence of employees #A1 and #A2, it was observed in Echocardiography Room 5425 at University Hospital, there was an unlocked refrigerator which contained medications. In interview, hospital staff indicated the housekeeping staff, who were not authorized to access the medications, cleaned the area on the 2nd shift when no department staff was there to monitor the housekeepers, even though the refrigerator was unsecured.</p>	S1028	<p><b>Tag S 1028 Rule # 410 OAC 15-1.5-7(d)(2)(E) Findings:</b> The hospital failed to secure access to one drug storage area within the hospital. <b>Corrective Action:</b> Medications were removed to a nearby secured refrigerator. A refrigerator that can be locked has been ordered. <b>Monitoring:</b> None required. <b>Responsible Persons:</b> Director of Echocardiography <b>Completion Date:</b> 12-15-2012</p>	12/15/2012			

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	2. Review of hospital Policy: MD 1.10 AP, approved July, 2010, entitled DRUG STORAGE GUIDELINES, indicated medications are stored in locked medication storage areas after ours and during periods of non-use or non-attendance by authorized personnel.			

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(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:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and document review, the hospital created conditions which resulted in a hazard to patients, public or employees in 5 instances.</p> <p>Findings:</p> <p>1. On 11-27-12 at 2:45 pm, in the presence of employees #A1 and #A2, it was observed in the dock storage area at University Hospital there were 14 fire extinguishers stored on the floor unsecured by chain or holder.</p> <p>2. On 11-28-12 at 10:15 am, in the presence of hospital staff, it was observed in the machine shop at University Hospital, there were 3 small acetylene tanks fire stored on the floor unsecured by chain or holder.</p> <p>3. Review of hospital Policy #: EC 3.03,</p>	S1118	<p><b>Tag S 1118 Rule # 410 IAC 15-1.5-8(b)(2) Findings:</b> Dock storage at University Hospital had 14 fire extinguishers stored on the floor unsecured by chain or holder. <b>Corrective Action:</b> Fire extinguishers were relocated to appropriate storage containers. <b>Monitoring:</b> Proper storage will be observed on weekly rounds. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Director of Facilities Management or designee <b>Completion Date:</b> 12-21-2012 <b>Tag S 1118 Rule # 410 IAC 15-1.5-8(b)(2) Findings:</b> The machine shop at University Hospital had three small acetylene tanks stored on the floor unsecured by chain or holder. <b>Corrective Action:</b> Tanks were secured immediately. <b>Monitoring:</b> Proper storage will be observed on weekly rounds. If</p>	01/03/2013

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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46206			
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	<p>approved April, 2011, entitled MEDICAL GASES, indicated free standing cylinders shall be properly secured or supported in a proper cylinder cart.</p> <p>4. If any of the above extinguishers and cylinders were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>5. At 1:30 PM on 11/27/2012, 1 of 4 CO2 tanks were unsecured in the back room of The Patio Deli located in Riley Hospital.</p> <p>6. While touring the medical gas storage area at Methodist Hospital on 11-26-12 at 1350 hours with B#2, 10 helium tanks were observed unsecured on the floor.</p> <p>7. While touring the receiving dock area at Methodist Hospital on 11-26-12 from 1345 hours to 1400 hours with B#2, it was observed that the large door to the water treatment room, where caustic chemicals are housed/stored, was open and the area was unsupervised creating a safety hazard to the public.</p>		<p>performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Director of Facilities Management or designee <b>Completion Date:</b> 12-21-2012 <b>Tag S 1118 Rule # 410 IAC 15-1.5-8(b)(2) Findings:</b> One of four CO2 tanks was unsecured in the back room of the Patio Deli at Riley Hospital. <b>Corrective Action:</b> Tanks were secured immediately. <b>Monitoring:</b> Proper storage will be observed on weekly rounds. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Director of Facilities Management or designee <b>Completion Date:</b> 12-21-2012 <b>Tag S 1118 Rule # 410 IAC 15-1.5-8(b)(2) Findings:</b> Ten helium tanks were unsecured on the floor at Methodist Hospital. <b>Corrective Action:</b> The tanks were removed and will not be replaced. <b>Monitoring:</b> None required. <b>Responsible Persons:</b> Director of Facilities Management or designee <b>Completion Date:</b> 1-3-2013 <b>Tag S 1118 Rule # 410 IAC 15-1.5-8(b)(2) Findings:</b> The large door to the water treatment room at the Methodist Hospital dock area was open and unsupervised creating a safety hazard to the public. <b>Corrective Action:</b> The door was secured,</p>				

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			staff were coached on proper security, and signage was posted. <b>Monitoring:</b> Proper security will be observed on an ongoing basis and on weekly rounds. If performance gaps are identified, staff will receive immediate retraining to ensure the deficiency is corrected and does not recur. <b>Responsible Persons:</b> Director of Facilities Management or designee <b>Completion Date:</b> 12-21-2012		

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S1162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the hospital failed to document annual preventive maintenance (PM) of 1 piece of mechanical equipment in accordance with the manufacturer's recommended maintenance schedule and did not document at all PM on 1 piece of mechanical equipment.</p> <p>Findings:</p> <p>1. Review of the manufacturer's recommended PM for the overhead operating room lights at University Hospital indicated there was a list of procedures to follow, including but not limited to, change secondary lamp, check light pattern and illumination levels, and ensure lighthouse moves through entire</p>	S1162	<p><b>Tag S 1162 Rule # 410 IAC 15-1.5-8(d)(2)(A) Findings:</b> The list of manufacturer procedures to follow for preventive maintenance had not been followed for the overhead operating room lights. <b>Corrective Action:</b> Lights at University Hospital lights were inventoried, added to the preventive maintenance database, and inspected. Risk ranking was evaluated, and future maintenance was scheduled. By December 5, 2012, operating room lights had been inspected, and minor repairs were complete. <b>Monitoring:</b> Preventive maintenance will occur as scheduled. <b>Responsible Persons:</b> Director of Clinical Engineering <b>Completion Date:</b> 12-5-2012 <b>Tag S 1162 Rule # 410 IAC 15-1.5-8(d)(2)(A) Findings:</b></p>	12/28/2012
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	<p>range of articulation.</p> <p>2. No documentation was presented by the facility that indicated the above PM activities were performed.</p> <p>3. In interview, on 11-28-12 at 12:15 pm, employee #A3 confirmed there was no documentation of the above PM activities were performed and no further documentation was provided prior to exit.</p> <p>4. On 11-28-12, hospital staff was requested to provide documentation of PM performed on a dish machine used at University Hospital. No documentation was provided.</p> <p>5. In interview, on 11-28-12 at 12:15 pm, hospital staff confirmed there was no documentation of PM performed on a dish machine and no further documentation was provided prior to exit.</p>		<p>There was no documented preventive maintenance on a dish machine at University Hospital. <b>Corrective Action:</b> Preventive maintenance was instituted on a routine basis. <b>Monitoring:</b> The Department Manager will assure preventive maintenance is conducted as scheduled. <b>Responsible Persons:</b> Director of Food Services or designee <b>Completion Date:</b> 12-28-2012</p>		

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S1318	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW &amp; DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C)(D)(E)(F)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and</p> <p>Based on document review and interview, the facility failed to ensure that inpatient transfers documentation was completed and sent to the gaining facility for 3 of 3 inpatient transfer medical records (MR) reviewed (Patient #18, 19 &amp; 20).</p> <p>Findings include:</p> <p>1. Review of policy/procedure NADM 1.22 AP, Patient Transfers, indicated the following: "B. External Transfers</p>	S1318	<p><b>Tag S 1318 Rule # 420 IAC 15-1.5-10(e)(3)(A)(B)2(D)(E)(F)</b> Three patients lacked documentation of a completed B-9 form. <b>Corrective Action:</b> 1. The Integrated Care Management Department staff were reeducated on expectations that the form is complete by January 2, 2013. The Integrated Care Management Department developed and implemented an audit tool January 2, 2013. <b>Monitoring:</b> 100% of the charts of discharged patients who are not discharged to home care or</p>	01/02/2013
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	<p>1. LIP responsibilities</p> <p>e. Complete Patient Discharge Instructions (B-9)</p> <p>2. Sending unit responsibilities</p> <p>b. Complete a brief nursing note regarding what facility the patient is going to, who care was handed off to, etc.</p> <p>d. Collaboration with Care Management on who copy all pertinent portions of the medical record to send with the patient.</p> <p>3. Integrated Care Management responsibilities</p> <p>f. Collaborate with nursing on who will copy all pertinent portions of the medical record to send with the patient." This policy/procedure was last reviewed/ revised on 11-2011.</p> <p>2. Review of patient #18's MR indicated the patient was transferred to another facility on 09-24-12 and the MR lacked documentation of a completed B-9 form and a brief nursing note of what facility the patient was going to and who care was handed off to.</p> <p>3. Review of patient #19's MR indicated the patient was transferred to another facility on 09-25-12 and the MR lacked documentation of a completed B-9 form and a brief nursing note of what facility the patient was going to and who care was handed off to.</p>		<p>self care will be audited for the first quarter of 2013 to ensure compliance of at least 90%. If performance gaps are identified, steps will be taken to assure staff complete documentation. A weekly summary will be provided to Department and Executive Directors to assure forms are complete. <b>Responsible Persons:</b> Director of Department of Integrated Care Management or designee. <b>Completion Date:</b> 1-2-2013</p>	

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	<p>4. Review of patient #20's MR indicated the patient was transferred to another facility on 09-25-12 and the MR lacked documentation of a completed B-9 form and a brief nursing note of what facility the patient was going to and who care was handed off to.</p> <p>5. On 11-29-12 at 1105 hours, staff #65 confirmed that completed B-9s were not in the MRs.</p>			