

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032
------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 004171</p> <p>Survey Date: 10-07-13 to 10-08-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson, BS ASCPMT Medical Surveyor 3</p> <p>QA: claughlin 10/21/13</p>	S000000	<p>Thank you very much for your visit. I have completed the on-line post-survey questionnaire requested regarding the visit and surveyors. However, I would like to reiterate that we received some excellent suggestions for continued improvement and have already begun to implement them. Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider 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.</p>	
S000322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032		
(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	
S000322	Based on document review and interview, the facility failed to ensure that all policy/procedures in use including system/ network policies were periodically approved for use by an authorized representative of the facility. Findings: 1. The IU Health network employee health policy titled Pre-Placement Health Assessment (revised 2-12) lacked documentation of approval by a representative of the IU Health North facility. 2. During an interview on 10-08-13 at 1515 hours, human resources manager A5 confirmed that the policy lacked documentation of approval by a facility representative.	S000322	For the purpose of any allegation that Indiana University Health North Hospital is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health North Hospital's credible allegation of correction and compliance. The Pre-Placement Health Assessment policy was reviewed and signed on November 1, 2013 by a IU Health North Hospital Facility representative. This policy will be updated as needed and reviewed at least triennially. Responsibility for continued follow up belongs to the Human Resource Manager.	11/01/2013	
S000394	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3) (f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following: (3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided. Based on document review and	S000394	For the purpose of any allegation	11/04/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032		
(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	
	<p>interview, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided for 10 contracted services.</p> <p>Findings:</p> <p>1. On 10-08-13 at 1050 hours, a list of contracted services was received from staff A6. The list of services lacked a description of the scope and nature of services provided and failed to indicate a service provider for air exchange certification, anesthesia machines, elevators, fire protection, generators, medical device reprocessing, medical physics, and 3 radiology equipment services.</p> <p>2. Review of facility contracts/agreements indicated the following: air exchange certification by CS1, anesthesia machine service by CS2, elevator service by CS3, fire protection services by CS4, generator service by CS5, medical reprocessing by CS6, medical physicist certification by CS7, and radiology equipment service by CS8, CS9 and CS10.</p> <p>3. On 10-08-13 at 1200 hours, staff A6 confirmed the list of contracted services lacked a description of the scope and nature of services provided and failed to</p>		<p>that Indiana University Health North Hospital is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health North Hospital's credible allegation of correction and compliance. The list of contracted services has been update utilizing the spreadsheet recommended by the ISDH surveyor. This includes Nature of services provided, as well as scope of responsibility. In addition we have created a process to address review of the Contracted services list semi-annually in January and July, added an agenda item to our weekly meetings for reporting of any changes to the contractor list, and a procedure for reporting new contractors attending our IU Health North Contractor Orientation. The following contractors have been added to the list. 1. Artec Enviromental Services for Air Exchange Certification, Aramark and Draeger for anesthesia machines, Otis for elevators, Koorsen-fire protection services, Macallister-generator services, Medissis-medical reprocessing, Medical Physics (MPC)-Radiation Safety, Siemens-MRI/Cath Lab, Alpha Imaging- Mamography Scanner. The Director of Operations will be responsible to ensure that this list is updated and accurate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032
------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
S000592	<p>indicate a service provider for air exchange certification, anesthesia machines, elevators, fire protection, generators, medical device reprocessing, medical physics, and 3 radiology equipment services.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</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:</p> <p>(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>(i) Sanitation. Based on document review and interview, the infection control (IC) committee failed to document review and approval of housekeeping policies for cleaning and disinfecting in the restricted operating room (OR) areas by</p>	S000592	For the purpose of any allegation that Indiana University Health North Hospital is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health North Hospital's credible	11/04/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032		
(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	
	<p>contracted service personnel .</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Environmental Cleaning in the Perioperative Setting (approved 3-13) lacked documentation of IC committee approval. 2. On 10-07-13 at 1400 hours, the infection prevention nurse A13 was requested to provide documentation of IC committee review/approval for the facility policy and the contracted environmental services policy for terminal OR cleaning if applicable and none was provided prior to exit. 3. During an interview on 10-07-13 at 1415 hours, staff A13 confirmed that no evidence of IC committee approval was available for the contracted service and facility terminal OR cleaning policies. 		<p>allegation of correction and compliance.The 'Surgical/Invasive Areas and Delivery Rooms-Terminal Cleaning at the end of each day' Policy has been entered into Policy Manager and has been approved by CNO, VP HR, and the Infection Prevention Coordinator as a representative of Infection Control Committee. The policy is the responsibility of the Infection Preventionist. The policy is in practice and is reviewed at a minimum of triannually.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032			
(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			
S000912	<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, other facility document review, observation, medical record review, and staff interview, the nurse executive failed to ensure the implementation of</p>	S000912	For the purpose of any allegation that Indiana University Health North Hospital is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health	11/04/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032		
(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	
	<p>facility polices related to expired products, dirty refrigerators and microwaves, and pediatric admission assessments for 1 of 1 PICU (pediatric intensive care unit) patient (Pt. #9).</p> <p>Findings:</p> <p>1. at 12:05 PM on 10/7/13, review of the policy and procedure "Code Cart: Checking and Restocking Supplies", with an effective date of 04/08/2011, indicated:</p> <p>a. under section "IV. Policy Statement", it reads: "A. The Code Cart will be checked at least once every 24 hours to ensure that all designated supplies/equipment are available, secured, and non-expired..."</p> <p>2. at 11:25 AM on 10/7/13, review of the "Charge RN (registered nurse) Daily Checklist", indicated:</p> <p>a. the day shift checked supplies in the ED (emergency department) most recently on 9/30/13, 10/1/13, 10/3/13, 10/4/13, 10/5/13, and 10/6/13</p> <p>b. the night shift checked ED supplies most recently on 9/30/13, 10/1/13, 10/2/13, 10/4/13, and 10/5/13</p> <p>3. at 11:15 AM on 10/7/13, while on tour of the ED in the company of staff members #59, RN and informatics specialist, and #60, informatics</p>		<p>North Hospital's credible allegation of correction and compliance. The code cart "daily checklist" will be audited for completion weekly. To be reviewed by manager and/or shift coordinator of ED. Due to short shelf life, all blood tubes have been removed from the ED triage room. They will be stocked in supply room on par level, which is managed by Manager of Materials. OR response to the finding of expired blood tubes found on the malignant hyperthermia cart. The Periop team has made a decision to have all blood tubes centralized in the supply rooms in all areas. These blood tubes have a short window of usage prior to expiration date. This supply area is monitored by the SIMS staff for restock and outdates. This was completed 11-1-13 with education to staff and surgeons. The Director (Jill Jesse) and Manager (Traci Hinton) coordinated the process with anesthesia tech and SIMS staff. For ED Code Carts, each individual drawer will be labeled with the item and date of the most recent expiration. These items will be removed and replaced prior to expiration. this process will be overseen by the ED manager. All unit pantry refrigerators cleaned weekly by EVS and/or food and nutrition staff and logged. All medication refrigerators cleaned monthly by</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032		
(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	
	<p>specialist, it was observed in the triage room that the following lab tubes had expired:</p> <ul style="list-style-type: none"> a. 4 blue top tubes that expired 6/13 b. 1 blue top tube that expired 3/13 c. 2 blue top tubes that expired 9/13 d. 1 pediatric microtainer (red) that expired 5/13 and one green top microtainer tube that expired 7/13 <p>4. at 11:25 AM on 10/7/13, while on tour of the ED in the company of staff members #59, RN and informatics specialist, and #60, informatics specialist, it was observed in the code cart across from the nurses' station that in drawer #2:</p> <ul style="list-style-type: none"> a. 2 microtainer red top tubes expired 9/13 b. 2 microtainer light green tubes expired 3/13 c. 2 red top lab tubes expired 6/13 d. 2 dark green top lab tubes expired 7/13 e. 2 orange top lab tubes expired 2/13 f. 2 light green top lab tubes expired 4/13 g. 2 purple top lab tubes expired 8/13 h. 2 blue top lab tubes expired 1/13 <p>5. at 11:30 AM on 10/7/13, while on tour of the ED in the company of staff members #59, RN and informatics specialist, and #60, informatics</p>		<p>Pharmacy staff and logged. 'Microwave Cleaning in Patient Nutrition Rooms and Family Retreats' Policy has been updated to reflect current practice. We trained the staff at our team meeting on cleaning procedure and frequency. Also procedure was written and signed off by each employee. Logs will be hung in protective plastic sheet covers. Manager of EVS to oversee process compliance. OFC and height documentation: The deficiency will be corrected with education, policy change, and audits with notification to associate. a. All staff were re-educated at the October staff meeting that OFC (2 years of age and younger) and height was requirement for admission documentation. Policy "Documentation Standards—Inpatient" will be updated by 11/8/13 to include Section IV. General Information B. Admission Standards b. enter the patients weight... c. For pediatric patients age 2 years and younger will have an OFC (occipitofrontal circumference) entered in centimeters (cm). Audits will be completed daily on admissions for height and OFC, beginning the date education was provided 10/24/13 for 30 days. Notification will be given to associates that are deficient in the required documentation. Carrie Lahr RN, BSN clinical operations manager for PICU is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032		
(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	
	<p>specialist, it was observed in the code cart across from the nurses' station that in drawer #5:</p> <p>a. 1 500 ml. NS (normal saline) IV (intravenous) solution had expired 3/13</p> <p>6. interview with staff member #65, the RN ED nurse manager at 11:30 AM on 10/7/13 indicated:</p> <p>a. nursing staff are checking the triage area and code carts and should be disposing of expired lab tubes, IV solutions, and other expired products</p> <p>b. the forms in drawer #2 and #5 indicated the products listed in 3., 4., and 5., above were all expired as listed on these forms</p> <p>7. at 10:50 AM on 10/8/13, while on tour of the surgery department, in the company of staff member #64, the RN surgery manager, it was observed in the MH (malignant hyperthermia) cart that 2 green top lab tubes had expired 8/13</p> <p>8. interview with staff member #64 at 10:50 AM indicated staff are to monitor the MH cart and remove expired products, including lab tubes</p> <p>9. at 3:55 PM on 10/7/13, review of the policy and procedure "Refrigerator/Freezer Temperature Monitoring", with an Effective date of</p>		<p>responsible for 1 and 2 completionThe education and Policy change will be completed November 8th, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032			
(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			
	<p>06/08/2013, indicated:</p> <p>a. under the section "IV. General Information", it reads: "Nursing Unit refrigerators/freezers-...Refrigerators will be cleaned once a week and outdated items removed. This includes appliances in the nourishment and medication rooms, etc. and appliances inside the patient rooms. The Manager is responsible to assign these duties and assure compliance..."</p> <p>10. at 1:45 PM on 10/7/13, while on tour of the LDR (Labor/delivery/recovery) unit in the company of staff member #55, the LDR manager, it was observed that the pantry microwave and refrigerator (especially under the vegetable drawers and the freezer bottom shelf) were dirty</p> <p>11. interview with staff member #55 at 1:45 PM on 10/7/13 indicated:</p> <p>a. the unit tech is responsible for maintaining clean appliances</p> <p>b. there is no documentation of routine cleaning of the microwave and refrigerator</p> <p>12. at 2:30 PM on 10/7/13, while on tour of the Family Retreat area of the NICU (nursery intensive care unit) in the company of staff member #67, the RN NICU manager, it was observed that:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032
------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
	<p>a. the refrigerator had dirty shelves and was dirty under the vegetable drawers</p> <p>b. the microwave had a large splatter of food on the door, walls and glass shelf of the appliance</p> <p>13. interview with staff member #67 at 2:30 PM indicated this staff member thought that housekeeping was responsible for cleaning the appliances</p> <p>14. at 10:25 AM on 10/8/13, while on tour of the recovery area of the surgery department in the company of staff members #64, the RN surgery manager and #66, the PACU (post anesthesia care unit) RN manager, it was observed in the pediatric side of the recovery room, in the nourishment refrigerator, that there were long hairs and crumbs/debris under the vegetable drawers, and under the glass shelf just above the vegetable drawers it was dirty/sticky</p> <p>15. interview with staff members #64 and #66 at 10:25 AM on 10/8/13 indicated there is no documented routine cleaning of the refrigerator</p> <p>16. at 11:20 AM on 10/8/13, while on tour of the pediatric nursing unit in the company of staff member #61, the RN peds/PICU (pediatric intensive care unit) nursing manager, it</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032			
(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			
	<p>was observed that the nourishment refrigerator had a red sticky substance on one of the door shelves and the top shelf of the refrigerator was sticky and with crumbs</p> <p>17. interview with with member #61 at 11:20 AM on 10/8/13 indicated: a. per the note attached to the refrigerator, the appliance is to be "...cleaned out every Monday or Tuesday..." b. there is no log or checklist to note the last time the refrigerator and who had cleaned it</p> <p>18. at 12:00 PM on 10/8/13, review of the policy and procedure "Documentation Standards--Inpatient", with an Effective date of 02/12/2012, indicated: a. under section "IV. General Information", it reads: "...B. Admission Standards 1. These elements are crucial to prompt and safe patient care and should be completed as soon as possible...b. Body Measurements...2. Body Measurements a. Enter the patient's weight..b. Enter the patient's height..."</p> <p>19. review of one pediatric (PICU) patient medical record (pt. #9) indicated: a. the patient was a one month old</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032		
(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	
S000952	<p>admitted on 9/25/13</p> <p>b. an admission weight was documented for the patient, but no length/height or OFC (occipital/frontal circumference) was noted in the medical record</p> <p>20. at 12:35 PM on 10/8/13, interview with staff member #52, the CNO (chief nursing officer), indicated:</p> <p>a. the current policy related to admission standards does not address OFC documentation at the time of admission for pediatric patients</p> <p>b. the current standard of practice is to obtain an OFC on admission for patients less than 2 years of age</p> <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, transfusion record review, and staff interview, the facility failed to follow approved medical staff policy/procedure for transfusion administration in five of</p>	S000952	For the purpose of any allegation that Indiana University Health North Hospital is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health	11/01/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032			
(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			
	<p>seven transfusion records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 10/8/13 review of a policy/procedure titled: "IU North Hospital, Blood Administration, Effective Date: 09/23/2011, Version: 5, Revision Date: 09/23/2014" which stated: " J. PROCEDURE STEPS, 11. Temperature, heart rate, respiration and blood pressure are taken and recorded before the transfusion is started....." 2. On 10/8/13 review of transfusion records indicated: <ol style="list-style-type: none"> a. T#1 started at 07:55, previtals taken at 07:55 b. T#2 started at 13:15, previtals taken at 13:15 c. T#3 started at 15:28, previtals taken at 15:28 d. T#4 started at 14:10, previtals taken at 14:10 e. T#5 started at 16:00, previtals taken at 16:00 where T =Transfusion. 3. On 10/08/13 at 03:00 p.m. staff person #8 acknowledged the above 5 transfusions were not administered in accordance with approved medical staff policy/procedure which indicated previtals are to be taken before the transfusions are started. 		<p>North Hospital's credible allegation of correction and compliance. Education flyer developed and distributed to all areas where blood transfusions occur. Managers reviewed in shift huddles. Placed in Training Tidbits. Flyers posted on units. Blood Bank Manager is responsible to audit monthly for compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032		
(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	
S001118	<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 document review, observation and interview, the hospital failed to monitor refrigerator temperatures used to store patient food for one refrigerator at the facility.</p> <p>Findings:</p> <p>1. The policy/procedure Refrigerator/Freezer Temperature Monitoring (approved 6-13) indicated the following: " The temperature of each refrigerator and each freezer used to store food ...will be monitored and documented at least daily for acceptable temperature ranges ... "</p> <p>2. During a tour of the central stores department on 10-07-13 at 1515 hours, a locked refrigerator/freezer was observed without evidence of daily temperature checks. When the refrigerator was</p>	S001118	<p>For the purpose of any allegation that Indiana University Health North Hospital is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health North Hospital's credible allegation of correction and compliance. Central stores (Materials Management) refrigerator temperatures will be taken each day and entered on refrigerator log. 4 box lunches are delivered to refrigerator located in materials management 2x week. This process will be monitored by Manager of food service.</p>	11/01/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032
------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
S001510	<p>unlocked and opened, 9 dated box lunches for patient use were observed.</p> <p>3. During an interview on 10-07-13 at 1515 hours, staff A7 confirmed that no documentation of temperature monitoring was present on the refrigerator or surrounding area.</p> <p>4. During an interview on 10-08-13 at 1345 hours, food services manager A9 confirmed that the refrigerator temperatures were not being monitored by dietary or central stores personnel.</p> <p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following:</p> <p>(A) Provision for the care of the disturbed patient.</p> <p>(B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care.</p> <p>(C) Provision for transfer of patients when care is needed which cannot be provided.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032			
(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			
	<p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the implementation of its policy related to patient transfers for 1 of 2 patients transferred from inpatient nursing units to another acute care hospital (pt. #15).</p> <p>Findings:</p> <p>1. at 4:10 PM on 10/8/13, review of the policy and procedure "Non-Emergent Transfer of Patients to another Facility", with an effective date of 12/22/2011, indicated:</p> <p>a. on page two under the section "V. Procedure", it reads: "...3...the physician must obtain the patient's written signature on the "Certification of Transfer" form." (policy attachment actually reads "Authorization for Transfer")</p> <p>2. review of patient medical records on 10/8/13 indicated that pt. #15:</p> <p>a. was transferred to another facility on 3/28/13 from the Medical 5 B nursing unit</p> <p>b. lacked a "Certification of Transfer" form in the medical record</p> <p>c. was alert at the receiving facility and signed a consent for admission and treatment at that facility</p> <p>3. interview with staff members #59, a</p>	S001510	<p>For the purpose of any allegation that Indiana University Health North Hospital is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health North Hospital's credible allegation of correction and compliance. Policy updated to reflect correct name "Authorization for Transfer". Process for obtaining signatures was reviewed. Nursing will assume responsibility for obtaining signatures. Form must be completed and be signed by physicians. Checklist to be developed and placed at each nursing unit to facilitate future transfers by 11/5/2013. Process to be monitored by Unit managers to ensure continued compliance.</p>	11/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032			
(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			
S002116	<p>RN (registered nurse) and informatics specialist, and #62, an informatics specialist, at 3:20 PM on 10/8/13 indicated:</p> <p>a. no consent to transfer form can be found for patient #15</p> <p>4. interview with staff member #53, the Director of Quality, at 5:00 PM on 10/8/13 indicated:</p> <p>a. further review of the medical record for pt.#15 indicated that no consent to transfer form can be found as required by facility policy</p> <p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8(c)(1)</p> <p>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:</p> <p>(1) A mechanism shall be maintained which specifies the delineated surgical privileges of each practitioner.</p> <p>Based on policy and procedure review, observation, and interview, the surgical department failed to ensure the implementation of its policy related to the improper use/disposal of surgical</p>	S002116	For the purpose of any allegation that Indiana University Health North Hospital is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health	10/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150161		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2013	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032			
(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			
	<p>masks for 3 staff members observed.</p> <p>Findings:</p> <p>1. at 4:10 PM on 10/8/13, review of the policy and procedure "Dress Code: Perioperative Practice Domain", with an effective date of October 2012, indicated:</p> <p>a. on page 4 under section "V. Policy Statements", it reads: "...C. Head/Face...4... Masks should not be worn hanging around the neck..."</p> <p>2. at 11:00 AM on 10/8/13, while on tour of the surgical department in the company of staff member #64, the RN (registered nurse) surgery manager, it was observed that 3 staff members were walking down the back hallway outside the sterile corridor with surgical masks hanging down around the neck</p> <p>3. interview with staff member #64 at 11:05 AM on 10/8/13 indicated that surgical masks are not to be hanging down about the neck, as stated in the facility policy</p>		<p>North Hospital's credible allegation of correction and compliance. The deficiency of staff wearing masks that are hanging down about the neck has been re-educated at the Oct 9th, 2013 OR staff meeting and OR Steering Meeting 18,2013 . There will be an ongoing process of reminders to sustain the model of practice. There will be signs hung in the hallways and lounges (staff and surgeon) to remove masks after leaving an OR suite upon completion of the case. The periop educators will be the responsible party for re-education. All staff will be monitors of the process to have no dangling masks out side of the OR suite.</p>				