

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
-------------------------------------------------------------	--------------------------------------------------------------------------------------

(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>This visit was for a standard licensure survey.</p> <p>Facility Number: 003776</p> <p>Survey Date: 8-5/7-13</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>QA: claughlin 08/15/13</p>	S000000		
S000102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on document review and interview, the facility failed to comply with all applicable state laws for 2 of 3</p>	S000102	Action Plan to Prevent Recurrence: We confirm that Patient Care Interns are now included in the IUHWH standard	08/26/2013

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: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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>unlicensed nursing assistant employee files reviewed (Staff #N1 & N5).</p> <p>Findings include:</p> <p>1. IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of employee #N1's employee file indicated that he/she was hired on 02-10-13 as a patient care intern (PCI) and employee #N1's file lacked documentation of a nurse aide registry report.</p> <p>3. Review of employee #N5's employee file indicated that he/she was hired on 11-19-11 as a PCI and employee #N5's file lacked documentation of a nurse aide registry report.</p> <p>4. On 08-07-13 at 1045, staff #49 confirmed that no nurse aide registry reports were completed for staff #N1 & N5.</p>		<p>new hire on-boarding process for non-licensed, patient care employee categories which require clearance from the Indiana Nurse Aide Registry within 3 business days of hire. Attached under supporting documents are forms that will be used to document INAR clearance findings prior to a PCI date of hire/start date. Long Term Monitoring: As indicated above, from this date forward all PCI new hire documentation: (New Hire Offer Checklist and New Hire Note) and will include INAR verification date and findings. A mandatory crosscheck by HR staff will be conducted prior to each new hire orientation.</p> <p>Responsible Leader: Lana L. Funkhouser, VP of Human Resources Supporting Documents to be attached: Preview letter/New hire checklist</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
-------------------------------------------------------------	--------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

S000270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 2 directly-provided services and 3 contracted services.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the directly-provided occupational therapy and speech pathology services.</p> <p>2. In interview, on 8-7-13 at 2:15 pm, employee #A3 confirmed the above and no further documentation was provided</p>	S000270	<p>Action Plan to Prevent Recurrence: Note of clarification, animal therapy is a directly-provided service not contracted. Quality monitor for the direct services of occupations therapy, speech pathology, and animal therapy to be presented to the Board of Directors on 9/9/13. Quality monitor for lithotripsy and pool nursing developed and will be presented to the Board of Directors on 9/9/13. See the attached monitors for supporting documentation. Long Term Monitoring: Quality monitors outlined above will be included in annual quality report to the Board annually in May. Responsible Leader: Lisa Sparks, RN, MHA, Vice President of Clinical Excellence, Corporate</p>	09/09/2013
---------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(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	
S000394	<p>prior to exit.</p> <p>3. Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the contracted services of animal therapy, extracorporeal shock wave lithotripsy and pool nursing.</p> <p>4. In interview, on 8-7-13 at 2:15 pm, employee #A3 confirmed the non-review of contracted services and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(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:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on review of documents and interview, the governing board failed to ensure that the hospital maintained an appropriate list of all contracted services in 1 instance.</p>	S000394	<p>Compliance/Privacy Officer Supporting Documents to be attached: Quality monitors for occupational therapy, speech therapy, animal therapy, contracted nursing and lithotripsy</p> <p>Action Plan to Prevent Recurrence: Current review and revision of listing of contacted services Long Term Monitoring: Annual review and revision of listing of contracted services Responsible Leader: Judy</p>	08/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(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>Findings:</p> <p>1. In interview, on 8-5-13 at 9:45 am, employee #A3 indicated the hospital had contracted services for Anesthesiology, Animal Therapy, Bioengineering, Dietetic Service, Electroencephalography, Extracorporeal Shock Wave Lithotripsy, Housekeeping, Laboratory, Laundry, Pool Nursing, and Transcription.</p> <p>2. Review of a Memorandum from A5 to A3 dated March 15, 2013, indicated IU Health West Hospital has ,, service contracts in place for people that are located onsite. It did not include contracted services of Animal Therapy, Dietetic, Electroencephalography, Extracorporeal Shock Wave Lithotripsy, and Laundry.</p> <p>3. In interview, on 8-7-13 at 2:30 pm, employee #A3 confirmed the above-stated Memorandum and no further documentation was provided prior to exit.</p>		<p>Coleman, COO & CFO Supporting Documents to be attached: List of contracted services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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			
S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include monitors and standards for 4 services directly-provided by the hospital and 6 services provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the directly-provided services of occupational therapy and speech pathology, and the contracted services of animal therapy, extracorporeal shock wave lithotripsy and pool nursing.</p>	S000406	Action Plan to Prevent Recurrence: Quality monitor for direct provided services of animal therapy, occupational therapy, speech therapy and the contracted services of lithotripsy and pool nursing developed. The developed quality monitors will be presented to the full Board of Directors for approval on 9/9/13. Long Term Monitoring: Quality monitors for above to be included in annual quality report to Board of Directors annually in May. Responsible Leader: Lisa Sparks, RN, MHA, Vice President of Clinical Excellence, Corporate Compliance/Privacy Officer Supporting Documents to be attached: Attached monitors included as supporting documentation	09/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
-------------------------------------------------------------	--------------------------------------------------------------------------------------

(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
S000554	<p>2. In interview, on 8-7-13 at 2:15 pm, employee #A3 confirmed the above and no further documentation was provided prior to exit.</p> <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 document review and interview, the facility failed to follow manufacturer's instructions in the usage of a disinfectant in 1 instance and failed to follow its policy in the usage of disinfectant test strips in 1 instance.</p> <p>Findings:</p> <p>1. Review of the manufacturer's instructions for the usage of CIDEX OPA Solution, a disinfectant, indicated the product was to be tested before each usage with the CIDEX OPA Solution test strips.</p> <p>2. In interview, on 8-5-13 at 11:45 am, a staff member of the Sleep Lab indicated the CIDEX OPA Solution was not tested before each usage with the CIDEX OPA Solution test strips.</p>	S000554	<p>Action Plan to Prevent Recurrence: New policy and employee competency developed to maintain compliance with manufacturer's recommendations for usage of Cidex OPA solution for disinfection. All staff has completed the competency. See attachment SDC.14 Cleansing and Disinfection of PAP Masks for policy and 2013 High Level Disinfection Competency for training tool Long Term Monitoring: Assistant Manager will monitor monthly Cides OPA log for compliance. Responsible Leader: Annette Flaskamp, Assistant Manager, Sleep Disorders Center Supporting Documents to be attached: SDC.14 High level disinfection competency tool</p>	08/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(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>3. Review of the manufacturer's instructions indicated the testing of positive and negative controls be performed on each newly opened test strip bottle of CIDEX OPA Solution Test Strips.</p> <p>4. In interview, on 8-5-13 at 11:45 am, a staff member of the Sleep Lab indicated there was not testing of positive and negative controls performed on each newly opened test strip bottle of CIDEX OPA Solution Test Strips.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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			
S000570	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2 (f)(1)(A)(b)(C)(D)(E) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (1) The infection control committee shall be a hospital or medical staff committee that meets at least quarterly, with membership that includes, but is not limited to, the following: (A) The person directly responsible for management of the infection surveillance, prevention and control program. (B) A representative from the medical staff. (C) A representative from nursing service. (D) A representative from administration. (E) Consultants from other appropriate services within the hospital, as needed.</p> <p>Based on document review and interview, the facility failed to establish an infection control committee that included a representative from nursing.</p> <p>Findings include:</p> <p>1. Review of the Infection Control Committee meeting minutes from 11-19-12, 01-28-13 and 03-25-13 lacked documentation that a representative from nursing service was a voting member of the infection control</p>	S000570	Action Plan to Prevent Recurrence: Revisions to Bylaws as below: 8/26/13 Approved by MEC 8/26/13 Sent out to voting members of full medical staff for vote 9/9/13 If above vote affirmed to full Board of Directors for approval Section VI: Infection Control Committee Composition: There shall be an Infection Control Committee, the majority of whom shall be members of the Active Medical Staff. Membership shall be multidisciplinary and may include both adult and pediatric Physician	09/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(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	
	committee. 2. On 08-06-13 at 1410 hours, staff #40 & 41 confirmed that representatives from nursing do not vote at the Infection Control Committee.		representatives from departments or subsections of Medicine, Surgery, Pediatrics and Pathology and Laboratory Medicine and Infection Prevention. In addition to active members of the medical staff, voting members of the committee shall include a member of Infection Prevention, Nursing, and Hospital Administration. Environmental Services and Hospital Facilities Department will be in attendance but without voting privileges. Representatives from Central Services, Laundry, Dietary, Pharmacy and Operating Rooms will be available on a consultative basis Continued triennial review by Bylaws Committee Long Term Monitoring: Continued triennial review by Bylaws Committee Responsible Leader: Greg Spurgin, MD, CMO Supporting Documents to be attached: None		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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			
S000596	<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. Based on document review, observation and interview, the facility failed to ensure the policy/procedure for terminal cleaning of the surgical suites was followed.</p> <p>Findings include:</p> <p>1. Review of policy/procedure SS 1.14, Environmental Cleaning in the Surgical Services Setting, indicated the following; "F. Terminal Cleaning 1. Surgical and invasive procedure rooms and scrub/utility areas must be terminally cleaned daily. 3. Terminal cleaning process for surgical and invasive procedure rooms includes, but is not limited to:</p>	S000596	<p>Action Plan to Prevent Recurrence: All EVS staff trained on the regulation to use approved disinfectant cleaner on the floor per policy SS 1.14 attached as supporting documentation. Approved disinfectant cleaner added to the OR closet. Monitoring of staff performing the floor cleaning by evening supervisor weekly. Long Term Monitoring: OR closet checked for correct approved disinfectant cleaner weekly. Observation of staff performing the floor cleaning by evening supervisor weekly. Responsible Leader: Toni Byrd, Director Environmental Services Supporting Documents to be attached: SS 1.14 Environmental Cleaning</p>	08/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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>e. Floor must be wet-mopped with an EPA registered hospital approved disinfectant." This policy/procedure was last reviewed/revised on 01-11.</p> <p>2. During the facility tour of the Surgical Services area on 08-06-13 at 1000 hours the following was observed in the environmental services closet for the Surgical Services area did not contain any EPA registered hospital approved disinfectant.</p> <p>3. On 08-06-13 at 1040 hours, staff #50 confirmed that a disinfectant is not used to terminal clean the operating room floors.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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			
S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire appropriate for work settings. Based on document review, observation and interview, the facility failed to ensure that surgery staff followed policy/procedure for operating room attire and followed AORN recommendations for cleaning operating room personnel's personal cloth caps.</p> <p>Findings include:</p> <p>1. Review of policy/procedure SS 1.07, Dress Code: Surgical Services Practice Domain, indicated the following: "C. Head/Face 1. Head and facial hair including sideburns and neckline will be covered. Standard, disposable bouffant and hood style covers are preferred."</p>	S000608	Action Plan to Prevent Recurrence: Update Dress Code Policy to require all staff to cover cloth hats with a bouffant disposable hat. Communicate in weekly newsletter about the changes Send out e-mail to all physicians and staff about new requirement Charge RN will monitor everyone entering the OR daily Post signage on the doors entering the OR Long Term Monitoring: RN charge nurse will monitor compliance daily, issues of noncompliance addressed on individual level by leadership team. Responsible Leader: Pam Chapman, RN, Director Surgical Services Supporting Documents to be attached: SS 1.07 Surgical Services Dress Code Policy Staff memo	09/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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>This policy/procedure was last reviewed/revised on 12-10.</p> <p>2. Review of the AORN Journal dated August 2010 indicated the following: "Fabric head coverings should cover the hair and scalp completely. Fabric head coverings should be laundered daily in a health care-approved or accredited laundry."</p> <p>3. On 08-06-13 at 0935 to 0945 hours with staff #41 & 42 in the Surgery Department, the following was observed in Operating Room 1; 2 operating room staff wearing personal cloth caps, in operating room 2; 1 operating room staff wearing a skull cap with neckline hair exposed and 1 operating room staff wearing a personal cap, in operating room 4; 1 operating room staff wearing a personal cap and in operating room 5; 2 operating room staff wearing personal caps.</p> <p>4. On 08-06-13 at 0945 hours, staff #42 confirmed the personal caps are not laundered at an accredited laundry facility.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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 document review and interview the facility failed to ensure that established standards of nursing care on the obstetrical inpatient unit was followed for 3 of 3 newborn medical</p>	S000912	Policy update with evidence based change; see attached policies MC 3.01 and Neo 1.03 Action Plan to Prevent Recurrence: Revised policies meet current newborn care	09/10/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(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>records (MR) reviewed (Patient #13, 14 & 15).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of policy/procedure MC/SCN 3.01, Care Guidelines for the Normal Newborn Infant, indicated the following on page 3: "V. Guidelines A. The recovery Period (The first 2-3 hours of life) 2. After Breastfeeding j. First bath will be done under radiant warmer in the LDRP room. Vital signs must be with in normal limits before bath is initiated. Temperature greater than 98.0 F." This policy/procedure was last reviewed/revised on 07-12. Review of patient #13's MR indicated the patient was delivered on 05-13-13 at 1009 hours. The patient's temperature was 97.7 degrees Fahrenheit prior to the first bath. Review of patient #14's MR indicated the patient was delivered on 06-06-13 at 1830 hours. The patient's temperature was 97.7 degrees Fahrenheit prior to the first bath. Review of patient #15's MR indicated 		<p>guidelines and matches clinical practice. Policy revision and practice guidelines discussed at staff meetings to be conducted on 9/5/13 and 9/10/13. Long Term Monitoring: Triennial review of guidelines and policies for compliance with evidence based practice. Responsible Leader: Marty Cox, RN, Director Women's and Children's Services Supporting Documents to be attached: MC 3.01 Neo 1.03</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
-------------------------------------------------------------	--------------------------------------------------------------------------------------

(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>the patient was delivered on 06-21-13 at 1208 hours. The patient's temperature was 97.7 degrees Fahrenheit prior to the first bath.</p> <p>5. On 08-07-13 at 1455 hours, staff #48 confirmed that patient #13, 14 & 15's MR indicated the patient's temperature was 97.7 degrees before the first bath.</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 review, transfusion record review, and staff interview, the facility failed to follow approved medical staff policies and procedures for 2 of 8 transfusions reviewed.</p> <p>Findings include: 1. On 8/5/13 at 3:00 p.m. review of a policy titled: "BLOOD and BLOOD COMPONENT ADMINISTRATION"</p>	S000952	Action Plan to Prevent Recurrence: Practice alert developed and distributed to nursing leaders for discussion at daily safety huddles. Alert highlights the timing requirements of the necessary documentation fields and specifically addresses that dispense time, pre-vitals, and start times must all be unique times. Long Term Monitoring: All transfusion record times will be monitored by blood bank staff;	09/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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>Effective June 2012 revealed: "Minimum Documentation Requirements" a. "1. Pre-transfusion Vital Signs: Record vital signs prior to transfusion initiation,..... b. 2. 15 Minutes Vital Signs: Between the first 10 and 20 minutes..... c. 4. Post Vital Signs: Take and record post-transfusion vital signs....."</p> <p>2. During Transfusion Record Review on 8/5/13 and 8/6/13: a. T#1 was dispensed from blood bank at 9:25 a.m. the same time the transfusion was documented as being started. Staff person can not be in 2 places at the same time. b. T#5 was started at 2325 which was the same time the documentation indicated the transfusion Pre Vitals were taken. Pre Vitals are to be PRE start of transfusion.</p> <p>3. In interview on 8/5/13 between 10:30 a.m. and 12:30 p.m., staff person #10 acknowledged the above transfusion records are as reported.</p>		<p>any identified issues of non-compliance will be reported to the nursing leader and education conducted with the individual employee. Responsible Leader: Mary Myers MSN, RN CENP CNO Supporting Documents to be attached: Blood Transfusion Practice Alert</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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 observation and document interview, the hospital created 1 condition which resulted in a hazard to patients and employees.</p> <p>Findings:</p> <p>1. Review of a document entitled REHABILITATION SERVICES WEEKLY HYDROCOLLATOR TEMPERATURE LOG, indicated if the temperature is found to be outside the acceptable range, contact Clinical Engineering.</p> <p>2. Further review of the above document indicated on 3-16-13 Hydrocollator II temperature was 168 and the Corrective Action if Variance, was Low on water, and on 3-18-13 Hydrocollators I and II temperatures were 168, each, and the</p>	S001118	Action Plan to Prevent Recurrence: Hydrocollator policy updated to include procedure on steps to take when temperature is out of range. Audit tool updated to include column to document action taken, i.e. contacting clinical engineering, see attached supporting documentation policy RS 1.13. Long Term Monitoring: Team leader will review temperature tracking tool each month to ensure that temperatures out of range were addressed in accordance with policy. Responsible Leader: Jeremy Enz PT, MBA Supporting Documents to be attached: RS 1.13	08/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(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	
S001168	<p>Corrective Action if Variance, was Cleaned Both I, II.</p> <p>3. In interview, on 8-5-13 at 12:40 pm, employee #A6 indicated Clinical Engineering would be contacted to determine if the department had any documentation of being contacted regarding the above hydrocollator temperatures being out of range. No further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, the hospital failed to keep a discharge log according to manufacturer recommendations for 1 of 1 defibrillators.</p> <p>Findings:</p> <p>1. Review of the LIFEPAK 20e Defibrillator/Monitoring Operating Instructions, indicated to Completer Operator's Checklist Daily. The</p>	S001168	Action Plan to Prevent Recurrence: Code cart checklist updated to include inspection of physical condition, "Checking both the LIFEPAK12 and the LIFEPACK20: Physical check includes: foreign substances, damage or cracks to machine; power cable must be checked for areas of breakage, looseness or wear; accessory cables must be inspected for cracking, damage, broken or bent parts or pins, or pitting on the paddle surfaces.	09/01/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
-------------------------------------------------------------	--------------------------------------------------------------------------------------

(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>Operator's Checklist included, but was not limited to:</p> <p>Inspect physical condition for: Foreign substances Damage or cracks</p> <p>Inspect power source for: Broken, loose, or worn power cable</p> <p>Examine accessory cables for: Cracking, damage, broken or bent parts or pins, and paddle surfaces for pitting</p> <p>2. Review of a document entitled CODE CART CHECKLIST indicated it did not include at least the above-stated items on the Operator's Checklist.</p>		<p>Check indicates that none of these are present." See attached code cart checklist for supporting documentation. Long Term Monitoring: Managers will review code cart checklist at the end of each month to make sure all checks are completed, f/u on any issues of noncompliance. Responsible Leader: Michael Luebbehusen, RN, MSN, Director MS/ICU/PCU Supporting Documents to be attached: 1.33a Code Cart Defibrillator Checks and Supplies</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013	
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(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			
S001186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy.</p> <p>Findings:</p> <p>1. Review of a document entitled FIRE DRILLS indicated scheduling will ensure that [fire] drills will be conducted once per shift per quarter in the hospital building and annually in the POC.</p>	S001186	Action Plan to Prevent Recurrence: A new fire drill procedure was created in ISISPro (the hospital's maintenance management software), calling for quarterly first-shift fire drills in each of the four off-site hospital services housed in the Professional Office Center. The first of the work requests calling for these actions will be issued on Sept. 1, 2013. Long Term Monitoring: Documentation will be reported to the EOC Committee on a quarterly basis. Responsible Leader: Mark Sluka, Director	08/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(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>2. Review of the hospital's license indicated the POC, located at 1115 N. Ronald Reagan Parkway, was an off-site and therefore, subject to all hospital rules and policies.</p> <p>3. Review of fire drills conducted at the facility in year 2012 indicated there was only 1 fire drill, on 4-19-12, at the POC.</p> <p>4. In interview, on 8-7-12 at 12:15 pm, employee #A6 confirmed there was only 1 fire drill at the POC and no further documentation was provided prior to exit.</p>		<p>Facilities Services Supporting Documents to be attached: Off-site fire drill procedure Off-site fire drill schedule</p>		