STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153028	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION HOSPITAL OF INDIANA INC	4141 SHORE DR INDIANAPOLIS, IN 46254

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S000000	This visit was for a standard licensure survey. Facility Number: 005971 Survey Date: 8-11/13-14 Surveyors: Jack I. Cohen, MHA Medical Surveyor Linda Dubak, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 08/29/14	S000000		
S000270	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (6) Review, at least quarterly,			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up. Based on document review and interview, the governing board failed to review reports of quality activities for 4 directly-provided services and 9 contracted services for calendar year 2013. Findings: 1. Review of the governing board minutes for calendar year 2013 indicated they did not include review of reports for the directly-provided services of animal therapy, biomedical engineering, housekeeping, and diagnostic radiology, 2. Review of the governing board minutes for calendar year 2013 indicated they did not include review of reports for the contracted services of biohazardous waste hauler, blood bank, housekeeping, laboratory, laundry, nursing, occupational therapy, physical therapy, and transcription. 3. In interview on 8-13-14 at 9:30 am, employee #A1 confirmed all the above and no further documentation was provided prior to exit.	S000270	RHI will develop quality metrics for all contracted services that will be reported through Quality Council on a quarterly basis before proceeding through Rehab Physicians Committee, Medical Executive Committee and the Board of Direrctors. RHI's Quality/Regulatory Director, Amanda Yazdani, will ensure that all contracted services are on the quality matrix and or will be sending quality reports that will be reviewed during the Quality Council Meeting before sending thorugh the appropriate governance bodies. Amanda Yazdani, Director, Quality/Regulatory is the responsible party.	10/01/2014

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S000322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (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: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on documentation review and staff interview, the Governing Board failed to ensure that foodservice policies were reviewed and approved annually as required by hospital policies and procedures. Findings included: 1. Policy Standardization Guidelines #ADM087 (last approved July 2014) indicated all hospital policies are to be reviewed and approved annually.	S000322	RHI's Dietary policies are up to date in the hospital policy management software system which includes validation of policy owners and Committee approval tracking. Dietary Manager was oriented to the policy management software. Annual policy reviews will occur in conjunction with RHI's Policy Standardization guidelines ADM87. John Delks, Director, Faciliities/Safety is the responsible party.	09/06/2014

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	2. Infection Control - Dietary Department policy #DTYD 1.05 (last approved September 2011) stated, (foodservice contractor), "contracted personnel for Dietary Department, functions according to established guidelines for infection control and food safety according to the" (foodservice contractor) "HACCP/Food Safety Program." 3. Dietician staff member A7 provided Infection Control - Dietary Department policy #DTYD 1.05 and (foodservice contractor) HACCP/Food Safety Program; both policies were documented that the previous review and approval of the policies and procedures was September 2011. 4. At 1:30 PM on 8/12/2014, Dietician staff member A7 indicated the (foodservice contractor) policies and procedures were last approved by the hospital September 2011. The staff member confirmed the foodservice's policies and			

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	procedures exceeded the annual review time frame as required by the hospital.			
S000406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include monitors and/or standards for 6 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. Findings: 1. Review of the facility's QAPI program indicated it did not include monitors and standards for the directly-provided services of animal therapy, biomedical	S000406	The identified direct provided services (6) along with the contracted services (6) have identified quality indicators that will be reported through RHI's Quality Matrix system. Amanda Yazadani is the responsible party. Indicators Added: Animal Therapy - added to press ganey patient satisfaction survey rating and benchmarks related to service dog therapy being beneficial and helping pateint meet their therapy goals; Biomedical Engineering - added response time requirement within 24 business hours of request; Housekeeping-RHI staff - added accountabilty sheets, isolation cleaning and mark test	10/01/2014

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	engineering, housekeeping, and diagnostic radiology, 2. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted services of biohazard waste hauler, blood bank, housekeeping, laundry, nursing, and transcription. 3. Review of the facility's QAPI program indicated it did not include standards for the directly-provided services at the Neuro Rehab and Carmel offsites. 4. In interview, on 8-13-14 at 9:30 am, employee #A1 confirmed all the above and no further documentation was provided prior to exit.		audits; Diagnostic Radiology - added # of film retakes needed based on total # of images taken; NRC and RHI Carmel outpatient services - added likelihood to recommend reference from patient satisfaction survey; Biohazard Waste Hauler - added # of pick up on time to total pick ups and # of additional times required for vendor response; Blood Bank - revised procedure and implemented process form to capture quality metrics related to # of units ordered/received, type of blood product, temperature of blood product; Housekeeping contract - # of time vendor notified for reclean; Laudry - # of linen that is unacceptable to received; Contracted Nursing - orientation, skills checklist, performance evals and error rate; Transcription - audit of turn around time within 24 hours from dictation to transcription;	
S000554	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, document review, and interview, the facility failed to maintain linen in a safe manner according to facility policy in two linen storage	S000554	Daily checks will occur to ensure the racks located in the storage area will be maintained appropriately. Inspection will include: 1. plastic covering is	09/24/2014

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	areas. Finding include; 1. On 8-11-14 at 11:20 am, in the presence of employee #A3, it was observed in the clean linen storage area, there were 4 sets of storage racks on which clean linen was stored. None of the racks was covered to protect the linen from being contaminated. 2. On 8/12/14 at 9:45 am, it was observed in the clean utility area of Unit 4, there was 1 linen storage rack with the cover to protect the linen up over the cart, leaving the clean linen exposed. 3. Hospital policy, Materials Management, MAT023, entitled Linen Processing and Management, Effective date 10/12/1992, Revised 5/5, stated, "Purpose To provide a guideline for the management of linen throughout the facility. Procedure, 1. All clean linen shall be covered at all time." 4. Interview with staff member, M#3 on Unit 4 indicated the clean linen should be covered at all times.		covering cart completely from top to bottom; 2. Integrity of plastic covering - no holes or tears. 3. Linen is organized neatly and organized on the carts. Larry Dodson, Manager, EVS/Security is the responsible party. Unit 4 linen storage - staff were re-educated on covering the linen cart each time linen is removed; Signage has been posted on the utility room door as a reminder. Assignments made to ensure compliance during rounding on each shift. Kathleen Davis, Nurse Program Director, Unit 4 is the responsible party.	
S000598	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)			

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	(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: (iv) Aseptic technique, invasive procedures, and equipment usage. Based on observation and staff interview, the facility failed to ensure the Carmel RHI Rehabilitation Center was complying with FDA requirements on not refilling Ultrasound Gel containers. Findings included: 1. FDA indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. However, past studies have demonstrated that ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial	S000598	No refilling of gel bottles. New bottles of gel will be purchased and when empty, disposed of. Individual gel bottles were purchased. If bulk gel is purchased, there will be new pumps and new containers to ensure there is no contamination in the system. Theresa Mull, PT, Manager, NRC/RHI Carmel is the responsible party.	08/20/2014

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	growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades. FDA recommends that Ultrasound Gel containers not to be refilled. 2. At 9:30 AM on 8/12/2014, the Carmel RHI Rehabilitation Center offsite was inspected. Located in a storage room was a counter with several 16-ounce ultrasound gel containers and a partial bulk plastic container of Aquasonic Ultrasound Gel. 3. At 9:45 AM on 8/12/2014, rehab staff member A18 indicated he/she refills the ultrasound gel plastic bottles. The staff member indicated a box containing a couple of plastic bottles and a bulk plastic container of Aquasonic Ultrasound Gel. The empty plastic container has to be refilled several times with the bulk container of ultrasound gel until the container is empty.			

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S000608	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix) (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: (ix) Requirements for personal hygiene and attire appropriate for work settings. Based on observation and document review, the facility failed to wash their hands between removing and changing single-use gloves in the kitchen. Findings Included: 1. Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-129, When to Wash Hands	S000608	Dietary Policy (DTYD001 - Infection Control - Dietary Department) has been revised to include documentation from 401 IAC 7-24-128) from the Indiana Food Code as an amendment to the HAACP guidelines set for by Treat Americe. Inservice education was conducted with staff which included proper techniques for handwashing. Weekly monitoring will be conducted by RHI's Dietician and reported to Infection Control.Results of monitoring will be included in hand hygiene	10/01/2014

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	states, "Food employees shall clean their hands and exposed portions of their arms as specified before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; When switching between working with raw food and working with ready-to-eat food; Before touching food or food-contact surfaces; Before placing gloves on hands; and after engaging in other activities that contaminate the hands." 2. At 9:45 AM on 8/11/2014, the hand washing sink wash basin located in the kitchen was observed dry with no evidence of hand washing at the hand washing lavatory. One kitchen cook and another kitchen staff member were		compliance which is reported through RHI's Quality Matrix. John Delks, Director, Facilities/Safety is the responsible party.	

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	observed changing their gloves multiple times without washing their hands prior to changing of gloves. The staff were observed reaching for a new set of gloves from boxes of gloves located at the prep stations and cooking areas. At least 15 boxes of single-use gloves were observed throughout the kitchen for easy access of staff which contributed toward staff not walking to the hand washing sink to wash hands. 3. At 11:00 AM on 8/11/2014, kitchen staff member A8 confirmed lack of hand washing during the inspection of the kitchen,			
S000744	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on document review and	S000744	Nurse Program Directors will	10/01/2014

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	interview, the facility failed to maintain complete nursing documentation of patient transfer to another facility and discharge documentation in 2 of 15 records reviewed (#10 and #13). Finding includes: 1. Medical record review on 8/13/14 at 8:30 am found: a. Patient record #10 was missing nursing documentation for the patient's transfer to another hospital. b. Patient record #13 was missing nursing documentation for the patient discharge and disposition upon discharge. 2. Interview with employee M#7 indicated the documentation was not available for review.		re-educate all nursing staff on the importance of discharge documentation. This includes the followin areas: Discharge documentation including Return To Acute Care and patient discharge instructions and handouts. Amanda Bushey, Director of Revenue Cycle, will conduct monthly auditing of records for discharge documentation compliance. Debra Cordes, CNO, is the responsible party for nursing education.	
S000788	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(9) (i) Emergency service records shall document and contain, but not be limited to, the following: (9) Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be			

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	recorded. Based on document review and interview the facility failed to maintain complete nursing documentation of patient transfer to another facility and discharge documentation in 1 of 15 records reviewed (#10). Finding includes: 1. Medical record review on 8/13/14 at 8:30 am found: a. Patient record #10 was missing nursing documentation for the patient's transfer to another hospital. 2. Interview with employee M#7 indicated the documentation was not available for review.	S000788	HIM will audit 30% of nursing discharge documentation and discharge instructions/handouts for three consecutive months after education is provided. The audits will be completed at the end of October, November and December based on that month's number of discharges. Amanda Bushey, Director, Revenue Cycle is the responsible party.	10/01/2014
S000912	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (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: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to,			

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	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.			
	Based on observation, document review and interview, the facility failed to maintain, according to policy, the defibrillator and crash cart checks on 1 of 4 units toured (unit #2). Finding include: 1. On 8/11/14 at 2:00 pm, on Unit 2 with employee M#1, it was noted the defibrillator crash cart checks were not being completed as required. 2. Code cart check list for Unit 2 cart indicated the cart was not checked on each shift. Documentation indicated the cart checks were not completed on 7 to 3	S000912	Mandatory training for all RNS and LPNs occurred from 9/2/2014 - 9/12.2014 regarding defibrillator and crash cart checks. Written handouts were provided. Code cart checks will take place every shift. Monthly monitoring will be conducted by the Nurse program Director. Training will be added to nursing employee orientation classes. Joan Taylor, RN, CRRN, Program Director, Unit 2 is the responsible party.	09/12/2014

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	shift on 7/1, 7/2, 7/3, and 7/10 on the 3 to 11 shift 7/4, 7/5, 7/6, 7/8, 7/9, and 7/10, on the 11 to 7 shift on 7/5, 7/6 , 7/9, and 7/10. 3. Hospital policy, Code cart check List Review on 6/14 indicated, "Purpose; To provide guidelines for checking the code cart and maintaining stock. Code carts may be checked by trained staff under the supervision of licensed health care providers. Procedure: A. Check carts. 1. Code carts on the nursing units will be checked every shift." 4. Interview with employee M#1 indicated the code carts were to be checked on each shift.			
S001162	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A) (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: (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended			

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	maintenance schedule. Based on documentation review, the facility failed to comply with manufacturer recommendations for 3 of 4 Hydrocollators located in the Rehabilitation Hospital of Indiana, Neuro Rehab Center offsite and Carmel RHI Rehab Center offsite. Findings included: 1. The Operation Manual instructions for the use and operation for Chattanooga Hydrocollator: M-4, E-1, and SS-2; Master Heating Units noted the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. Operating Temperature for all models is 160 to 166 degrees Fahrenheit. The Hydrocollator that Rehabilitation Hospital of Indiana, Neuro Rehab Center offsite, and Carmel RHI Rehab Center offsite were manufactured by Chattanooga Group Inc.	S001162	Trimedx, RHI's Biomechanical engineering contractor, was contacted to check the Hydrocollator at RHI Carmel where it was determined that the thermometer used to read the temperature for this unit was defective. That thermometer was replaced and the thermostat was reset for the appropriate temperatures at Carmel as well as those located at NRC and RHI's 38th street facility. RHi's Policy on Hydrocollator temperature maintenance has been revised to include accuracy checks of the thermometer on a monthly basis. The policy also includes the temperature requirements of 160-166 degrees per manufacturer guidelines. Temperatures will be recorded weekly. A water temperature log will be maintained on a monthly basis to ensure temperatures are within recommended ranges. Larissa Swan, OTR, Executive Director, Therapies is the responsible party.	10/01/2014

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	2. Rehabilitation Hospital of Indiana had a Chattanooga M-4 model Hydrocollator. The temperatures were recorded weekly for the previous 31 weeks. The Hydrocollator log noted that 31 of 31 weeks, the temperature exceeded 171 degrees Fahrenheit which exceeded the maximum operating temperature of 166 degrees Fahrenheit. 3. Neuro Rehab Center offsite had a Chattanooga SS-2 model Hydrocollator. The temperatures were recorded weekly for the previous 31 weeks. The Hydrocollator log noted that 31 of 31 weeks the temperature was registering between 150 and 159 degrees Fahrenheit which fell short of the minimum operating temperature of 160 degrees Fahrenheit. 4. Carmel RHI Rehab Center offsite had two Chattanooga Hydrocollators: E-1; SS-1. However, only the E-1 model			

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	Hydrocollator was not registering between 160 and 166 degrees Fahrenheit. The temperatures were recorded weekly for the previous 31 weeks. The E-1 Hydrocollator log noted that 31 of 31 weeks, the temperature was registering between 140 and 150 degrees Fahrenheit which fell short of the minimum operating temperature of 160 degrees Fahrenheit.			
S001164	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment.			

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	Based on document review and interview, the hospital failed to provide evidence of current preventive maintenance (PM) for 10 pieces of equipment. Findings: 1. On 8-11-14 at 11:55 am, employee #A3 was requested to provide documentation of PM on a pill packaging machine in the pharmacy. 2. On 8-11-14 at 12:15 pm, employee #A3 was requested to provide documentation of PM on a TransSit device in physical therapy gym #2. 3. On 8-11-14 at 12:20 pm, employee #A3 was requested to provide documentation of PM on a toaster, blender, refrigerator, and electric burner top stove in the occupational therapy area. 4. On 8-11-14 at 12:25 pm, employee #A3 was requested to provide documentation of PM on an electric skillet used as a cast hydrocollator. 5. On 8-12-14 at 9:10 am, employee #A17 was requested to provide documentation of PM on a stair step device at the Neuro Rehab offsite.	S001164	Preventative maintenance processes and tracking of service tags have been added on: 1. Pill packager in pharmacy (vendor completed annual performance maintenance on 8.20.2014; PM service tag added for monthly monitoring; Neil Patel, Manager, Pharmacy is the responsible party for this equipment. 2. TransSit device in Gym 2 was added to Facility Work order system on 8.19.2014 had performance maintenance completed on 8.19.2014; PM service tag was added to equipment and included on monthly monitoring; 3. Kitchen appliance in OT Kitchen including toaster, blender, refrigerator, electronic burner stove had PM performed on 8.19.2014 and was added to Trimedx work order system; 4. Electric skillet that was being used as a cast hydrocollator was removed on 8.21.2014. A commercial grade hot water splint pan was purchased and added to the Trimedx work order system; PM service tag was placed. 5. Stairstep at NRC was added to facility work order system on 8.20.2014; PM performed and service tag placed for equipment monitoring. John Delks, Director, Facilities/Safety is the responsible party.	08/21/2014

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	6. In interview, on 8-13-14 at 9:15 am, employee #A3 indicated there was no PM documentation on all the above-stated items and no other documentation was provided prior to exit. 7. On 8-12-14 at 9:30 am, it was observed at the RHI-Carmel offsite was observed there were parallel bars and rehab steps without a preventive maintenance tag on them. 8. On 8-12-14 at 9:40 am, rehab staff member #A18 indicated the above-sated items at the Carmel offsite have never had a preventive maintenance performed on them.			
S001186	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal			

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	and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. Based on documentation review and staff interview, the facility failed to provide documented fire drills for Neuro Rehab Center offsite and Carmel RHI Rehab Center offsite. Findings included: 1. Emergency Preparedness Plan (Code Red) Fire Plan #SM 10.16 (Last approved June 2014) stated, "Fire drills will be held once a quarter on each shift." 2. The 2013 and 2014 Rehabilitation Hospital of Indiana Fire Alarm Drill Report and Critique identified neither Neuro Rehab Center offsite and Carmel Rehab Center offsite logged on the report.	S001186	Fire drills were completed at RHI Carmel and NRC the week of 8.25.2014. Drills will be conducted quarterly at NRC, RHI Carmel and at the off site Patient Financial Services location in accordance with RHI's policy on fire drills. John Delks, Director, Facilities/Safety is the responsible party.	08/25/2014

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	3. At 3:30 PM on 8/12/2014, facility staff member A3 indicated he/she could not locate documentation that fire drills were conducted for 2013 and 2014 offsite locations.			
S001197	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F) (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: (F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on documentation review and staff interview, the facility failed to conduct monthly inspections of the K-extinguisher located in the kitchen. Findings included: 1. Emergency Preparedness Plan (Code Red) Fire Plan #SM 10.16	S001197	K extinguisher was added to Facility Work Order system on 8.11.2014 to perform monthly check by Maintenance. System will ensure monthly monitoring. John Delks, Director Facilities/Safety is the responsible party.	08/14/2014

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	(last approved June 2014) stated, "Fire extinguishers will be inspected annually by contracted vendor and monthly by Security/Maintenance Staff." 2. At 10:00 AM on 8/11/2014, a K-extinguisher was observed located on the wall in the kitchen of the hospital. The extinguisher was observed with an annual inspection yellow tag attached to it. The tag noted it was placed on the extinguisher September 2013. The tag noted spots for monthly inspections and none of the months were initialed. 3. At 10:15 AM on 8/13/2014, maintenance staff member A3 confirmed the fire extinguisher located in the kitchen had missed its required monthly inspections.			