

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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
S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 005051 Survey Date: 04-20/23-2015 QA: cjl 05/12/15 IDR Committee Meeting 06-17-15; changes made to Tag S1118. JL	S 0000		
S 0554 Bldg. 00	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 and interview, the hospital created 2 conditions that failed to provide a healthful environment that minimized infection exposure and risk to patients. Findings: 1. On 4-21-2015 at 10:55 am, in the presence of employees #A1, Facilities	S 0554	S554 410IAC 15-1.5-2 INFECTION CONTROL The hospital failed to provide a healthful environment that minimized infection exposure and risk to patients in two conditions. Findings: Meals on Wheels patient meals found in paper sacks on cart located at back dock Corrective Action(s): Beginning June 1, 2015 all Meals on Wheels patient meals will be stored in the main kitchen at IU	06/20/2015

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: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>Manager, #A5, Safety Supervisor, #A6, Physician Education, and #A7, Director Facilities, it was observed in the back dock area there was a cart/rack with 9 small closed paper bags, each having a patient label affixed to them. It was also observed there were large delivery trucks using the dock and no one was monitoring the cart/rack.</p> <p>2. In interview, on the above date and time, hospital staff indicated the bags were part of the Meals on Wheels program and awaiting pick-up for delivery to patients.</p> <p>3. Hospital staff was requested to provide documentation of a policy/procedure pertaining to the activity of storing Meals on Wheels packages for delivery to patients. No documentation was provided prior to exit.</p> <p>4. There was no policy to address appropriately storing of the bagged meals. They were unattended, and subjected to weather, temperature and contamination. This posed an infection exposure and risk to patients.</p> <p>5. On 4-21-2015 at 1:00 pm, in the presence of employees #A1, #A5, #A6, and #A7, it was observed in the central distribution area of Methodist Hospital,</p>		<p>Health Methodist Hospital for pick up. Appropriate kitchen staff will be informed of new procedure by June 1, 2015. By June 20, 2015 a policy regarding storage and handling of Meal on Wheels patient meals will be created by the Manager of Nutrition Services for approval by the Policy Steering Committee. Monitoring: Periodic random observations will take place to assure appropriate procedures are followed so the deficiency is corrected and will not recur. Feedback will be provided to kitchen staff during staff meetings. Responsible Person: Manager of Nutrition Services along with Nutrition Services Supervisors Findings: Nutritional supplements being stored uncovered and exposed to light in the central distribution area at IU Health Methodist Hospital Corrective Action(s): By June 1, 2015 all Nutritional supplements in Central Distribution will be kept in storage boxes. All staff in Central Distribution have been educated on light sensitivity of nutritional supplements and proper storage. Monitoring: Periodic random observations will take place to assure appropriate procedures are followed so the deficiency is corrected and will not recur. Feedback will be provided to central distribution staff during staff meetings. Responsible Person: Manager Operation Supply Chain</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202		
(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	
S 0912 Bldg. 00	<p>there were the following items stored on metal wire racks, uncovered and completely exposed to light:</p> <p>4 1 liter containers of TwoCal- HN nutritional supplement 2 1 liter containers of Osmolite 1.2 cal nutritional supplement</p> <p>6. Each of the containers had a manufacturer's label affixed that indicated contains light sensitive material. Due to the prolonged exposure to light, the above items may have become ineffective.</p> <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</p>		Management		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>to provide care for all patient care areas of the hospital.</p> <p>(ii) Maintaining a current nursing service organization chart.</p> <p>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.</p> <p>(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.</p> <p>(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, observation, and interview, the nursing executive failed to ensure that nursing staff implemented polices and expectations related to: refrigerators, freezers, blanket warmers, equipment cleaning, microwaves, and patient confidentiality.</p> <p>Findings:</p> <p>1. Review of the policy "Refrigerator and Freezer Temperature Monitoring", policy number SF 1.02 AP, last approved on February 2014, indicated:</p> <p>a. Under V. "Policy Statements", in section C. it reads: "The temperature of each refrigerator and each freezer used to store food, or specimens in patient care areas will be monitored and documented daily when open for business for</p>	S 0912	<p>S912 410 IAC 15-1.5-6 NURSING SERVICE The nursing executive failed to ensure that nursing staff implemented policies and expectations related to: refrigerators, freezers, blanket warmers, equipment cleaning, microwaves, and patient confidentiality. Findings: The Methodist Endoscopy area lacked checking of refrigerator temperature on April 9 and 10, had a dirty refrigerator, and March temperature logs exceeded range and there was no documentation of facilities maintenance being notified. Corrective Action(s): The dirty refrigerator was immediately cleaned by staff. By June 20, 2015 all Endoscopy staff will be reeducated on the Refrigerator and Freezer Temperature Monitoring policy (SF 1.02)</p>	06/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>acceptable temperature ranges."</p> <p>b. Under "VI. Procedures", it reads: "A. Temperature Monitoring 1. Manual temperature monitoring:...b. Check refrigerator and freezer temperature daily, record on the log...3. If the temperature is still out of range at the 60 minute re-check, contact Facilities...".</p> <p>c. Under "VI. Procedures", it reads in section C. "Maintenance of Refrigerator/Freezer 1. Routine weekly cleaning of interior pantry refrigerators will be handled by Nutrition Services when restocking items. Cleaning of exterior will be handled by Environmental Services. 2. Nursing is responsible for any spills that occur in between cleaning/restocking."</p> <p>2. While on tour of the Methodist Hospital Endoscopy area on 4/20/15 at 12:20 PM, in the company of staff members #55 and #56, surgical area managers, it was observed that:</p> <p>a. The April 2015 "Daily Refrigerator/Freezer Temperature Log" lacked the checking of the refrigerator temp on April 9 and 10.</p> <p>b. The refrigerator had a sticky dried liquid product on the door shelves and inside of the refrigerator.</p> <p>3. Interview with staff members #55 and #56 indicated:</p>		<p>regarding proper temperature monitoring and cleaning. By June 20, 2015 EVS staff and Nutrition and Dietetics staff will be reeducated on the Refrigerator and Freezer Monitoring policy (SF 1.02) regarding responsibilities for cleaning. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency has been corrected and will not recur. EVS will use Trakker program to capture data and generate quality reports. Responsible Person: Director of Perioperative Services Findings: Methodist Emergency Department found to have dirty refrigerator. Corrective Action(s): The dirty refrigerator was immediately cleaned by staff. By June 20, 2015 all Nursing staff, EVS staff, and Nutrition and Dietetics staff will be reeducation on the Refrigerator and Freezer Temperature Monitoring policy (SF 1.02) regarding responsibilities for cleaning. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency has been corrected and will not recur. EVS will use Trakker program to capture data and generate quality reports. Responsible Person: Clinical Manager of Emergency Department Findings: Saxony Emergency Department found to have dirty refrigerator.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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 unit was not closed on 4/9/15 and 4/10/15 and should have had the refrigerator temperature documented.</p> <p>b. Nursing is responsible for cleaning the refrigerator.</p> <p>c. Nursing does not document on the "Daily Refrigerator/Freezer Temperature Log" when they clean the refrigerator, and it cannot be determined the last time the refrigerator was cleaned.</p> <p>4. Review of the March Endoscopy unit "Daily Refrigerator/Freezer Temperature Log" indicated that every day the unit was open, nursing staff noted the refrigerator temperature was above the temperature range expected (40 degrees) and there was no notation of contact with the facility maintenance department regarding this. (At the top of the form it indicates: "If the temperature is found to be outside of the acceptable range for more than 1 hour (in shaded area), contact Facilities and request services...".)</p> <p>5. At 2:00 PM on 4/20/15, while on tour of the ED (emergency department) of Methodist Hospital in the company of #59 and #60, the ED managers, it was observed that the ED side by side refrigerator had crumbs in the vegetable drawer, and the shelves of the refrigerator and door had dried, spilled, liquids</p>		<p>Corrective Action(s): The dirty refrigerator was immediately cleaned by staff. By June 20, 2015 all Nursing staff, EVS staff, and Nutrition and Dietetics staff will be reeducation on the Refrigerator and Freezer Temperature Monitoring policy (SF 1.02) regarding responsibilities for cleaning. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency has been corrected and will not recur. EVS will use Trakker program to capture data and generate quality reports. Responsible Person: Clinical Manager of Emergency Department Findings: The ICU/PCU unit at Saxony hospital was found to have dirty freezers and ice buildup. Corrective Action(s): The freezers were immediately cleaned and defrosted. One of the freezers was taken out of service. On May 26, 2015 the unit began piloting small, frost free freezers in each patient room. By June 20, 2015 all Nursing staff, EVS staff, and Nutrition and Dietetics staff will be reeducation on the Refrigerator and Freezer Temperature Monitoring policy (SF 1.02) regarding responsibilities for cleaning. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>present.</p> <p>6. Interview with staff members #59 and #60 indicated that EVS (environmental services), nursing and dietary all share in the cleaning of the refrigerator/freezer.</p> <p>7. At 9:43 AM on 4/21/15, while on tour of the Saxony ED in the company of staff member #61, the director of clinical operations, and #62, the ED manager, it was observed that the top of the refrigerator was dusty on top, had crumbs in the door gasket, and spillage between the glass shelf and the lip of the vegetable drawer that it rests on.</p> <p>8. At 9:45 AM on 4/21/15, interview with staff member #61 indicated that EVS cleans the outside of the refrigerators, and nursing cleans the inside.</p> <p>9. At 2:05 PM on 4/21/15, while on tour of the combined med/surg, ICU (intensive care unit), PCU (progressive care unit) nursing units, in the company of staff members #63, the facility program manager, and #64, the unit clinical coordinator, it was observed that the clean supply/utility room had two full sized freezers, for ortho patient ice packs, that had:</p> <p>a. 1 to 2 inches of built up ice on each</p>		<p>has been corrected and will not recur. EVS will use Trakker program to capture data and generate quality reports. Responsible Person: Clinical Manager of ICU/PCU area Findings: Methodist PACU found to have blanket warmer with large accumulation of dust. Corrective Action(s): The blanket warmer was immediately cleaned. By June 20, 2015 the Environmental Services staff will be reeducated on the Blanket and Fluid Warmers policy (SF 1.10) which outlines requirements for cleaning. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency has been corrected and will not recur. EVS will use Trakker program to capture data and generate quality reports. Responsible Person: Director of Perioperative Services Manager of PACU Findings: Saxony Emergency Department found to have dirty dynamap. Corrective Action(s): The dynamap was immediately cleaned. By June 20, 2015 the Environmental Services staff will be reeducated on proper cleaning of equipment. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency has been corrected and will not recur. EVS will use Trakker program to capture data and generate quality reports.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>of the coil shelves within the freezers.</p> <p>b. Debris present in both freezers, and two small hairs present in one freezer.</p> <p>c. Dust present on the tops of both freezers.</p> <p>10. Interview with staff member #63 indicated the freezers had an egregious amount of ice present, appeared to have not been cleaned for quite some time, and that this is nursing's responsibility.</p> <p>11. Review of the policy "Blanket and Fluid Warmers", policy number SF 1.10 AP, last approved on June 2012, indicated:</p> <p>a. Under "VI. Procedures", it reads in section 2.: "Cleaning: to reduce the spread of infectious agents, the interior of the warmer will be wiped down by Environmental Service staff members monthly and when visibly soiled."</p> <p>12. At 11:45 AM on 4/20/15, while on tour of the Methodist Hospital PACU (post anesthesia care unit) in the company of staff member #52, the manager of peri operative services, it was observed that the AMSCO blanket warmer had a large accumulation of dust under the plenum of the top warmer cabinet. (dust balls the size of jaw breakers)</p>		<p>Responsible Person: Clinical Manager of Emergency Department Findings: Saxony Cath Lab found to have dirty anesthesia carts. Corrective Action(s): The anesthesia carts were immediately cleaned. By June 20, 2015 the Environmental Services staff will be reeducated on proper cleaning of equipment. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency has been corrected and will not recur. EVS will use Trakker program to capture data and generate quality reports.</p> <p>Responsible Person: Clinical Manager of Cath Lab Findings: Methodist Endoscopy area found to have dirty code cart and dirty dynamap. Patient label from 4/17/15 found on top of bronchoscopy machine. Corrective Action(s): The code cart and dynamap were immediately cleaned. The patient label was immediately removed and disposed of. By June 20, 2015 the Environmental Services staff will be reeducated on proper cleaning of equipment. By June 20, 2015 the Endoscopy staff will be reeducated on patient confidentiality and proper disposal of patient sensitive information. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency has been corrected and will not</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>13. At 9:55 AM on 4/21/15, while on tour of the Saxony ED in the company of staff member #62, the ED manager, it was observed in the triage room that the Dynamap (vital signs) machine had a large amount of dust built up on the base of the unit.</p> <p>14. At 9:57 AM on 4/21/15, staff member #62 reported that the room is not utilized, so the equipment had not been cleaned recently, and that nursing staff are responsible for cleaning their equipment.</p> <p>15. On 4/21/15, at 9:15 AM and 9:20 AM, respectively, while on tour of the Saxony Cath lab area in the company of staff member #57, the director of the cath lab, the anesthesia supply cart in room #3, and the anesthesia medication cart in room #3, were observed to be dusty on the tops of the carts.</p> <p>16. Interview with staff member #57 at 9:25 AM on 4/21/15 indicated that nursing staff are to wipe down equipment in the cath lab.</p> <p>17. At 12:15 PM on 4/20/15, while on tour of the Methodist Hospital Endoscopy area, in the company of staff members #55 and #56, perioperative managers, it was observed:</p>		<p>recur. EVS will use Trakker program to capture data and generate quality reports. Responsible Person: Director of Perioperative Services Findings: The third floor nursing unit on Saxony was found to have a dirty microwave. Corrective Action(s): The microwave was immediately cleaned. By June 20, 2015 the staff of the unit and EVS staff will be reeducated on proper cleaning of the microwave. Monitoring: Beginning June 20, 2015 this area will be monitored on a regular basis during EVS rounding to ensure the deficiency has been corrected and will not recur. Responsible Person: Clinical Manger of unit</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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. In the Endoscopy area that the top of the code cart, behind the defibrillator, was dusty.</p> <p>b. In the Endoscopy area that the base of the Dynamap machine in bay #14 had an accumulation of dust present.</p> <p>c. In bronchoscopy room #61, a patient hospital sticker with name, medical record number, etc. was lying on the top of the bronchoscopy machine.</p> <p>18. At 12:20 PM on 4/20/15, interview with staff members #55 and #56 indicated:</p> <p>a. Nursing is responsible for cleaning the tops of code carts and the base of the Dynamap machines.</p> <p>b. The patient, whose hospital sticker was found on top of the bronchoscopy machine, was a patient the previous Friday (4/17/15) and when nursing cleaned the machine, this label should have been removed, as this is a breach of confidentiality.</p> <p>19. Review of the document "Microwave Oven Safety" (no policy number and no approval date), indicated on page two: "...Cleaning Instructions Clean the door and interior (the outer edge too) with water and mild detergent. Do not use abrasives such as scouring pads."</p> <p>20. At 1:45 PM on 4/21/15, while on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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
S 0952 Bldg. 00	<p>tour of the Saxony hospital 3rd floor pantry area in the company of staff members #63, the facility program manager, and #64, the unit clinical coordinator, it was observed that the microwave had a considerable amount of splattered dried food on the interior of the door, the walls, and the round glass plate within the equipment.</p> <p>21. At 1:50 PM on 4/21/15, interview with staff members #63 and #64 indicated:</p> <p>a. There is no policy related to the cleaning of microwaves.</p> <p>b. It was thought that housekeeping staff cleaned equipment in the pantry every morning.</p> <p>c. It was "obvious" to staff member #64 that nursing staff had used the microwave and failed to clean the splatters after use.</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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202		
(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	
S 1024	<p>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, record review, and staff interview, the facility failed to follow approved medical staff policies and procedures for one (#11) of twelve transfusions reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of approved policy/procedure titled: "Blood and Blood Component Administration, Approved April 2012, Effective June 2012, Revised April 2015," read "VI. Procedures, B. Minimum Documentation Requirements, 1. Pre-transfusion Vital Signs prior to transfusion initiation, including: temperature, heart rate, respiration, and blood pressure." Review of 12 transfusion records, 3 from each hospital, Riley, University, Methodist, and Saxony, indicated transfusion #11 from Saxony Hospital had the pre vitals taken the same time the transfusion was started. In interview on 4/23/15 at 2:00 p.m., SP#13 acknowledged the Blood and Blood Component policy/procedure had not been followed. 	S 0952	<p>S952 410 IAC 15-1.5-6 NURSING SERVICE The facility failed to follow approved medical staff policies and procedures for one of twelve transfusions reviewed. Findings: One blood transfusion record reviewed from Saxony hospital had pre vitals taken the same time the transfusion was started. Corrective Action(s): By June 20, 2015 the nurses at IU Health Saxony hospital will be reeducated via the Blood Transfusion Fast Facts Flyer regarding the importance of completing pre vitals prior to transfusion initiation. This information will also be discussed during June staff competencies and daily huddles in June 2015. Monitoring: Beginning in June 2015, Blood Bank will audit transfusion documentation completion and feedback will be provided to the Director Clinical Operations for IU Health Saxony. Reports will be shared at the IU Health Saxony Quality Council. Responsible Person: Director Clinical Operations Program Manager Quality, Risk, Compliance, Infection Control and Patient Safety</p>	06/20/2015	
	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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
Bldg. 00	<p>410 IAC 15-1.5-7 (d)(2)(C)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction.</p> <p>Based on document review, observation and interview, the department of pharmacy failed to follow its policy/procedure regarding expired pharmaceutical products being removed from operational areas at Goodman Hall; neurophysiology departments.</p> <p>Findings:</p> <p>1. The policy/procedure Expired Pharmaceutical Product and Patient Own Medication Disposal, Policy # 5.66, last reviewed 11/2013, indicated the following:</p> <p>A. Expired pharmaceutical products that originated from the Pharmacy Department will be removed from the operational areas.</p>	S 1024	<p>S1024 410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES</p> <p>The department of pharmacy failed to follow its policy/procedure regarding expired pharmaceutical products being removed from operational areas at Goodman Hall.</p> <p>Findings: Radiology area of Goodman Hall had expired medications in emergency drug box. Corrective Action(s): The deficiency was corrected at the time of the survey, when it was noticed by the survey team. The expired medications were removed from the area and replaced with in date medications. The Pharmacy Technician assigned to perform monthly inspections of the area will check to ensure all medications are in date and replaced as necessary at least one month before expiration.</p>	05/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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
S 1118 Bldg. 00	<p>2. During a tour on 04/21/2015 at 1045 hours of the radiology and infusion suites of the Brain Tumor Clinic, it was observed that the shared emergency drug box had nine types of expired drugs. Expired medications included: two (2) syringes of Atropine 100 mcg/ml., 2 syringes of epinephrine, 0.3 mg., 2 syringes of epinephrine, 1:10,000, 1 mg/10 ml., 4 vials of furosemide 40 mg/4 ml, 1 vial of glucagon, 1 mg, 4 syringes of Heparin Lock flush 50 U/5 ml, 2 bottles of odansetron 4 mg/2 ml, injectable, 4 bottles of promethazine 25 mg/ml, injectable, and 3 diphenhydramine, 25 mg capsules.</p> <p>3. On 04/21/2015 at 1100 hours, neurophysiology staff member #1 concurred with the above findings.</p> <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</p>		Compliance is tracked electronically and completed reports are sent to the Technician Supervisor monthly. In the event the inspection is not recorded, the Technician Supervisor and Technician assigned the task is sent an automated electronic e-mail starting 10 days before the end of the month. If the task goes overdue, an e-mail is sent to the Pharmacy Technician Coordinator in addition to the above listed staff. Monitoring: The medications will be checked every month during the unit inspection. Responsible Person: Monthly oversight – Pharmacy Technician Supervisor, Pharmacy Manager and Director of Pharmacy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202		
(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>employees. Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 2 instances (cardiopulmonary therapy waiting area, physical therapy area) at Indiana University Health Morgan Hospital and in 1 of 5 laboratory areas of Indiana University Hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 04-20-2015 at 12:30 pm in the presence of employees #A3, Manager Facilities and #A4, Safety Coordinator, it was observed in the cardiopulmonary therapy waiting area at IU Morgan, there was an alcohol-based hand sanitizer (ABHS) affixed to a wall directly over a portable space heater. On 04-20-2015 at 1:00 pm in the presence of employees #A3 and #A4, it was observed in the physical therapy area at IU Morgan, there was an ABHS affixed to a wall directly over electronic phone/computer equipment. In both of the above cases, the sanitizers being located directly over an electrical ignition source, posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source. 	S 1118	<p>S1118 410 IAC 15-1.5-8 PHYSICAL PLANT Findings: Alcohol based hand sanitizer affixed to wall above a space heater as well as over electronic phone/computer equipment at Morgan Hospital. Corrective action: Hand sanitizer above electronic equipment was relocated. Space heater was removed from area. Monitoring: Will monitor for placement of/electrical equipment surrounding alcohol based hand sanitizers during monthly Environment of Care rounds per existing routine. Responsible person: Manager Facilities/Maintenance Findings: No eye wash stations in the following locations at University Hospital: Phlebotomy area, FNA Lab, Pheresis area Corrective action: Liquid bleach in the FNA lab will be replaced with bleach wipes for use. IDR requested for the citations in the Phlebotomy and Pheresis areas as no corrosive materials exist in said areas. See attached supporting document. Monitoring: Lab leadership to ensure no liquid bleach is ordered for this area. Responsible person: Director, Office of Compliance, Accreditation and Quality Pathology Laboratory</p>	06/20/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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
S 1168 Bldg. 00	<p>4. On 4-22-15 between 12:30 p.m. and 2:00 p.m., the FNA laboratory area was observed that did not have an eye wash and the FNA lab was closed but a large bottle of bleach was observed through the window in the door. No eyewash could be seen and there was no area for a shower.</p> <p>5. SP#6 acknowledged the lack of eyewash in the FNP lab.</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 and observation, the hospital failed to follow the manufacturer's recommendation for daily testing of its defibrillators in 2 instances.</p> <p>Findings:</p> <p>1. Review of the manufacturer's manual</p>	S 1168	POC Update 7/20/15 Deficiency ID: S _ 1168 Findings: No spare battery pack accompanied the defibrillator unit in Nuclear Medicine. Corrective Action: Zoll Medical Corporation adding verbiage to the owner's guide to include recommendations for spare batteries or AC mains power from a local wall outlet. Proposed changes to the guide in	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>for the hospital's Zoll defibrillators, indicated an Operator's Checklist for R Series Product. Review of the Checklist indicated the following categories of recommended checks and procedures to be performed daily:</p> <p>Condition - unit clean, no spills, clear of objects on top, case intact Hands-free Therapy electrodes Paddles Inspect cables for cracks, broken wires, connector Batteries - fully charged battery in unit, and fully charged battery available Disposable supplies Operational checks</p> <p>2. Review of a document entitled ADULT CODE CART/DEFIBRILLATOR CHECKLIST, used by the hospital for daily defibrillator checks, indicated the following categories were not indicated:</p> <p>Condition Batteries</p> <p>3. Review of the manufacturer's manual indicated under the heading Daily Visual Inspection, Batteries, to check that a fully charged spare battery pack accompanies the unit.</p>		<p>process of Zoll regulatory and legal approval. Draft is attached. Please see the highlighted changes on pages 1-16, 12-2, and 12-11. A member of the emergency response team will be responsible to bring a backup battery where a Zoll defibrillator will be used as defined per policy ADM 1.33 Response to Medical Emergencies. The spare battery will be available for those code responses in areas where no other defibrillator units or emergency power is readily available (i.e. common areas of the hospital). The Zoll defibrillator back up batteries will be on site by 8/20/2015. By 9/20/2015 all education and implementation will be completed. Education: Representatives from Zoll will help with education specific to the charging and changing of the batteries. Key persons to be included in the education are those who respond to codes within the identified risk areas (respiratory therapists, nurses and privileged providers from ICUs) where no emergency power is readily available and where no other defibrillator units are in the immediate area. Responsible persons: Respective AHC Code Team committee chairs Monitoring: As is currently occurring, respective AHC Code Team committees will monitor medical emergency response outcomes. S1168 410 IAC 15-1.5-8 PHYSICAL PLANT</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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
S 1226 Bldg. 00	4. On 4-21-2015 at 10:05 am in the Nuclear Medicine area, in the presence of employees #A1, Facilities Manager, #A5, Safety Supervisor, #A6, Physician Education, and #A7, Director Facilities, there was a defibrillator for use. It was also observed no spare battery pack accompanied the unit. 410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9 (b)(2)		Findings: Review of the Adult Code Cart/Defibrillator Checklist indicated the category of 'condition' was not indicated. Corrective action: Adult Code Cart/Defibrillator Checklist was modified to include instructions to check the condition of the defibrillator unit (see attached, page 2, #7) as stated in the manufacturer's instruction manual. Monitoring: Will monitor as part of existing Environment of Care rounds to affirm adherence checklist completion. Responsible person: Clinical Educator Adult Critical Care & Multi-Specialty Critical Care and AHC Safety Supervisor Findings: No spare battery pack accompanied the defibrillator unit in Nuclear Medicine. Corrective Action: Requesting IDR for this finding. In the event of a battery failure for a defibrillator, staff are instructed to retrieve and use a defibrillator from a neighboring unit. Additionally, in the event of a power failure, emergency power is available and indicated for defibrillator use per hospital policy. See attached policy EC 7.26. Zoll Manufacturer supports IU Health's decision to utilize another defibrillator and use of emergency power. See attached letter from Zoll.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>(b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows:</p> <p>(2) Equipment shall be inspected, tested, and calibrated at least annually by qualified personnel with appropriate documentation reasonably available.</p> <p>Based on document review, observation, and interview, the facility failed to follow its policy/procedure and maintain appropriate documentation of medical physics inspection, testing and calibration at least annually on its radiologic equipment for 1 of 21 equipment reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Radiation Safety: Patient (approved 7-13) indicated the following: "Annual radiographic calibrations on Radiology Department equipment and diagnostic units outside the department are performed by a State certified inspector." During a tour on 4-20-15 at 1350 hours of the Riley Hospital Emergency Department (ED), a ThermoScientific Mini C Arm (#132683) was observed without evidence of inspection and 	S 1226	<p>S1226 410 IAC 15-1.5-9 RADIOLOGIC SERVICES</p> <p>Findings: A ThermoScientific Mini C Arm was observed without evidence of inspection and certification by a Physicist in 2014 or 2015. Corrective action: Physicist inspection was completed on 4/24/15. Physicist report and inspection date photo attached. Monitoring: Institution of contracted services tracking system will trigger alerts to Clinical Engineering as new equipment contracts are approved. This will provide a queue for Clinical Engineering to anticipate new equipment arrival. Responsible person: Manager, Supply Chain Manager of Contracts/Negotiations and Director of Clinical Engineering</p>	04/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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
S 2116 Bldg. 00	<p>certification by a physicist in 2014 or 2015.</p> <p>3. During an interview on 4-21-15 at 1630 hours, chief safety officer A3 confirmed that no documentation of a recent inspection and calibration by a physicist was available for the ED radiologic equipment observed on tour.</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 document review, observation, and interview, surgical staff failed to follow their policy related to peri operative dress code in two surgical areas toured.</p> <p>Findings: 1. Review of the policy "Dress Code: Perioperative Practice Domain", policy number POS 1.07, last approved October 2012, indicated:</p>	S 2116	S2116 410 IAC 15-1.6-8 Surgical Services Findings: Methodist Surgery Areas: RNs and surgeons wearing surgical masks down about the neck. Methodist OB Surgery Area: CST wearing dangling earrings not covered by surgical bouffant cap. Saxony Cath Lab: RN wearing surgery mask down about the neck. Corrective action: Periop Dress Code Policy under review at present. Following final approval of Periop Dress Code policy:	06/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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. Under "V. Policy Statements", in section A. "General", in item #5., it reads: "...Dangling jewelry is not to be worn when providing direct patient care unless confined within scrubs (bracelets, earrings, necklaces)...".</p> <p>b. Under "V. Policy Statements", in section C. "Head/Face", it reads in item #4: "Masks are to cover the mouth and nose completely...Masks should not be worn hanging around the neck...".</p> <p>2. On 4/20/15, while on tour of the Methodist Hospital surgical areas, in the company of RN (registered nurse) #51, a scribe, and #52, the peri operative services manager/director, it was observed that:</p> <p>a. At 11:45 AM, in the PACU (post anesthesia care unit), one physician was noted to have their surgical mask dangling about the neck.</p> <p>b. At 12:45 PM, one surgeon in the surgery hallway was with their surgical mask down about the neck.</p> <p>c. At 1:02 PM, one RN in the surgical hallway was with their surgical mask down about the neck.</p> <p>3. On 4/20/15, while on tour of the OB (obstetrics) surgical area at 1:15 PM in the company of staff member #52, the peri operative services manager/director, it was observed that the CST (certified</p>		<p>Methodist Surgery Areas: Methodist Surgery Dept. will re-educate staff during OR staff meetings. Surgeons will receive re-education during the Quality Council meeting. Emphasis will be placed on the policy statement regarding surgical masks. Re-education will occur by June 20, 2015. Methodist OB: Prior to June 20, 2015, revised dress code policy will be included in a weekly email to unit staff and staff will be asked to review. Surgeon re-education of policy will occur during the June Professional Practice Committee meeting. Emphasis will be placed adherence to jewelry restrictions in the peri-op areas. Saxony Cath Lab: Email will be sent out to staff with policy attached. Staff will be asked to review the policy. Emphasis will be placed on adherence to proper use and disposal of surgical masks. All re-education will be completed by June 20, 2015. Monitoring: Expectation for peer to peer monitoring with immediate feedback provided if non-compliance is witnessed. Responsible persons: Director Clinical Operations for Women's Services, Director Perioperative Services at Methodist Hospital, Program Manager of Quality/Safety at Saxony Hospital.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
---	---

(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>surgical tech) in the hallway, had dangling earrings that were not covered by their surgical bouffant cap.</p> <p>4. At 11:50 AM on 4/20/15, interview with staff member #52 indicated surgical masks are not to be worn down about the neck.</p> <p>5. At 1:20 PM on 4/20/15, interview with staff member #52 indicated dangling earrings are to be confined within the bouffant surgical cap.</p> <p>6. On 4/21/15, while on tour of the cath lab at Saxony hospital in the company of staff members #53, the cath lab coordinator, and #54, the cath lab director, indicated that at 9:41 AM, a RN was noted transporting a patient from the cath lab area with their surgical mask down about the neck.</p>			