

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151306	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH PAOLI HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 642 W HOSPITAL RD PAOLI, IN 47454
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005065</p> <p>Survey Date: 3-24/26-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Ken Ziegler Medical Surveyor</p> <p>QA: cloughlin 04/02/14</p>	S000000	Agree.	
S000362	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D) (E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors.</p> <p>(B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement.</p> <p>(C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor.</p> <p>(D) Use discretion and sensitivity in contacts with potential organ donor families.</p> <p>(E) Notify the appropriate procurement organization of potential organ donors.</p> <p>(F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review and interview, the hospital failed to comply with their contract by not notifying their organ procurement organization of 1 of 36 deaths for the year 2013.</p> <p>Findings:</p> <p>1. Review of the contract between the hospital and the Indiana Organ Procurement Organization (IOPO), dated February 28, 2007, indicated [the] hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or</p>	S000362	A new IOPO agreement has been requested through Andy Ley at IOPO. He states the IOPO agreements are with his COO and that they are being updated due to new CMS requirements. Andy Ley said he would provide us the new agreement as soon as he receives it from his COO. The new agreement will be reviewed and appropriate signatures will be obtained. The IU Health Paoli policy was followed. The gestational age was 28 weeks. The policy will be updated based upon the new agreement. May 1, 2014 the new IOPO agreement was obtained.	05/30/2014			

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S000406	<p>who has died (including calling prior to or at the time Brain Death is declared), in the Hospital.</p> <p>2. Review of a report entitled IU Health Paoli Hospital Donation 2013 Statistics and Benchmarks, indicated for the period January 1, 2013 through December 31, 2013, there were 36 hospital deaths and 35 were reported to IOPO.</p> <p>3. In interview, on 3-26-14 at 9:55 am, employee #A3 indicated the one death was not reported because the patient was less than 38 weeks gestation. The employee also indicated the hospital policy indicated patients less than 38 weeks gestation did not need to be reported to IOPO.</p> <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>		Agreement will be signed as soon as a few questions are answered. Sonya Zeller will complete task.		

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S000592	<p>(1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include standards for 1 service directly-provided by the hospital as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's QAPI program indicated it did not include standards for the directly-provided service of security. In interview, on 3-26-14 at 12:30 pm, employee #A2 confirmed the above and no further documentation was provided prior to exit. <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not</p>	S000406	The 2014 Security Scorecard has standards/targets/benchmarks. All of the other Scorecards were reviewed for standards and all were completed. The Quality Council will review Scorecards for standards to ensure completion. Shayna Rosenbaum, the Quality Manager, is responsible for Scorecard completion.	04/24/2014			

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	<p>limited to, the following:</p> <p>(i) Sanitation. Based on interview and document review, the infection control committee failed to ensure that the environmental services was following facility policy for cleaning in the Surgical Services Department and failed to address use of a disinfectant for each step of the cleaning process on a daily basis or overall state that a disinfectant is to be used.</p> <p>Findings include:</p> <p>1. Staff member #H1 indicated the following in interview beginning at 11:30 a.m. on 3/25/14: (A) He/she uses Windex for the glass cabinet doors in the operating rooms.</p> <p>2. Review of policy titled "CLEANING DUTIES ENVIRONMENTAL" last reviewed/revised 3/12/14 indicated the exterior cabinet doors are to be cleaned on a weekly basis with a disinfectant cleaner, however the daily cleaning of the cabinet doors does not specify a disinfectant is used. Several steps of the policy indicate a disinfectant is used, however there are also several steps that state "are cleaned" such as the doors and handles, surgical lights and tracks and the cabinet doors and would not require staff</p>	S000592	<p>1. The Windex was removed from cleaning supplies on March 25, 2014.2. The Environmental Cleaning in the Intra-Operative Perioperative Setting policy was reviewed and updated. Education was provided based upon the new policy and competency was completed through the use of the AORN standardized cleaning procedure for the environmental cleaning staff. The Hospital approved disinfectants are being utilized for cleaning. Debbie Rutherford, RN, Nurse Director Surgery Department, completed the education, competency and will sustain the appropriate cleaning per policy and AORN standards.</p>	04/24/2014	

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S001022	<p>to use a disinfectant.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)</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>(B) Appropriate storage conditions. Based observation, interview, and document review, the hospital failed to follow its policy to appropriately store Schedule II controlled substances (C-II's) in 1 instance.</p> <p>Findings:</p> <p>1. On 3-24-14 at 1:20 pm, in the presence of employees #A1, #A2, and #A3, it was observed that the front door to the Pharmacy was locked. It was also observed within the Pharmacy department, there was an open door that was propped open. It was also observed there were medications stored in this room and there was no pharmacy staff in this room or going in and out of this room.</p>	S001022	The door to the Scheduled II controlled substances was closed and locked prior to the surveyor leaving the Pharmacy on March 25, 2014. The door will remain closed and locked to maintain appropriate storage conditions. The policy is being updated and education will be provided by May 2, 2014. Pam Bond, RPh, MBA, VP, is responsible for maintaining the appropriate storage conditions.	05/02/2014	

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S001028	<p>2. In interview, on the above date and time, a pharmacist indicated the room was the narcotic closet which stored Schedule II controlled substances. The staff person also indicated the door was left open, even during after hours when the pharmacy was not occupied. The staff person further indicated the State Board of Pharmacy required Schedule II controlled substances to be double-locked, the front door providing the first lock.</p> <p>3. Review of hospital POLICY NUMBER: 20-1700, entitled Controlled Drug System, last reviewed 02/26/2014, indicated Schedule II Controlled Substances ... should be locked in the narcotic closet immediately after they are checked on.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals</p>			

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	<p>are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on observation, interview, and document review, the hospital failed to ensure a policy indicating who could access medications in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. In interview, on 3-24-1 at 3:25 pm,, a staff Physical Therapist indicated the medication dexamethasone was stored in a locked cabinet in the physical therapy department. Upon further interview, the staff Therapist indicated there was none stored at the moment. 2. At the above date and time, the staff Therapist was requested to unlock the cabinet. In the presence of employees #A1, #A2, and #A3, it was observed the staff Therapist unlocked the cabinet. 3. On the above date and time, employee #A2 was requested to provide a hospital policy indicating who had authority to access medications. 4. Review of the personnel file of a staff Physical Therapist, including the Job 	S001028	The policy for who has the authority to access medications has been reviewed and is being updated. This task will be completed by May 2, 2014.Pam Bond, RPh, MBA, VP is responsible for the policy update and the continued monitoring of access to medications.	05/02/2014

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S001150	<p>Description, indicated there was no documentation the Therapist had authority to access medications.</p> <p>5. In interview, on 3-25-14 at 4:00 pm, employee #A3 indicated there was no policy indicating who had authority to access medications and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 3 instances.</p> <p>Findings:</p> <p>1. On 3-24-14 at 1:05 pm in the presence</p>	S001150	All three backflow prevention devices were installed on March 27, 2014. Brett Webb, Director of Plant Facilities, will maintain the presence of the backflow prevention devices.	03/27/2014			

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S001164	<p>of employees #A1, #A2 and #A3, it was observed in the janitorial closet of the outpatient surgery area there was a flexible hose connected to a water spigot without a backflow prevention device.</p> <p>2. On 3-24-14 at 2:15 pm in the presence of employees #A1, #A2 and #A3, it was observed in a mechanical area of the north wing of the machine room, there was a flexible hose connected to a water spigot without a backflow prevention device.</p> <p>3. On 3-24-14 at 2:45 pm in the presence of employees #A1, #A2 and #A3, it was observed in a housekeeping storage area, there was a flexible hose connected to a water spigot without a backflow prevention device.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients,</p>			

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S001168	<p>as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 1 piece of equipment.</p> <p>Findings:</p> <p>1. On 3-24-14 at 11:55 am, employee #A2 was requested to provide documentation of PM on a portable x-ray machine.</p> <p>2. In interview, on 3-25-14 at 3:35 pm, employee #A5 indicated there was no documentation of PM on the portable x-ray machine. The employee further indicated there was no hospital policy for PM on this piece of equipment and no other 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</p>	S001164	The Service Engineer with General Imaging was contacted to complete the preventative maintenance on the portable x-ray machine. The Service Engineer is on vacation this week, April 21, and plans to complete preventative maintenance the week he returns, April 28. Beth Parsley, Director of Medical Imaging, will call the Service Engineer on April 28 to remind him to service the equipment no later than May 9, 2014. April 29, 2014 The Preventive Maintenance was completed on the portable x-ray machine and will be completed annually. The Director of Medical Imaging will be responsible for the annual completion of preventative maintenance.	05/09/2014			

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	<p>discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the hospital failed to follow the manufacturer's recommendation for daily testing of 1 of 1 defibrillator.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the manufacturer's manual for a hospital defibrillator, indicated a recommended checklist to test and inspect the device on a daily basis. The LIFEPAK 12 defibrillator/monitor Series OPERATOR'S CHECKLIST indicated the following: <ul style="list-style-type: none"> 1. Inspect physical condition for: <ul style="list-style-type: none"> Foreign substances Damage or cracks 2. Inspect Power Source for: <ul style="list-style-type: none"> Broken, loose, or worn battery pins Damaged or leaking battery Two fully charged batteries installed Fully charged spare batteries available Optional Power Adapter plugged into unit and ac or dc power source LED's are lit Broken, loose, or worn optional power adapter cables 3. Check therapy and ECG 	S001168	The Defibrillator Checks policy and the Monitor/Defibrillator/Crash Cart Check Log have been updated to indicate the equipment is checked per manufacturer's recommendation. Baili Campbell, RN, has updated the policy and educated staff. She will maintain the updated policy through practice.	04/25/2014

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	<p>electrodes for: Expiration date Spare electrodes available</p> <p>4. Examine accessory cables for cracking, damage, broken or bent parts or pins, and paddle surfaces for pitting</p> <p>2. Review of hospital POLICY NUMBER: 35-319, entitled Defibrillator Checks, last reviewed 03/14/2014, indicated the purpose [of the policy is] to ensure emergency monitoring equipment is in working condition per manufacturers guidelines</p> <p>3. Review of a document entitled MONITOR / DEFIBRILLATOR / CRASH CART CHECK LOG, for February 2014 for the North Wing / Ob, indicated a date column and a column titled Monitor/Defib User Test. The staff person completing the document each day indicated the status of the Monitor/Defib User Test. There was no other documentation on the log indicating the above-mentioned manufacturer's recommended checks.</p> <p>4. In interview, on 3-25-14 at 3:35 pm, employee #A4 confirmed the MONITOR / DEFIBRILLATOR / CRASH CART CHECK LOG was used to document</p>						

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S001186	<p>testing of the defibrillator. The employee also indicated it did not conform to the manufacturer's requirements. No further documentation was provided prior to exit.</p> <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 in 1 instance.</p>	S001186	A fire drill will be conducted once per quarter per shift in the Medical Arts Building (MAB) where IU Health Paoli Rehabilitation Services is located. IU Health Paoli Rehabilitation	04/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151306		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH PAOLI HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 642 W HOSPITAL RD PAOLI, IN 47454			
(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			
S001906	<p>written documentation of a regular state or local fire inspection, or request of same, for calendar year 2013.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 3-24-14 at 11:55 am, employee #A2 was requested to provide documentation of the hospital's most recent State or local fire inspection, or request for inspection, for calendar year 2014. In interview, on 3-25-14 at 3:50 pm, employee #A2 indicated the last time there was a documented fire inspection was in year 2009. No further documentation was provided prior to exit. <p>410 IAC 15-1.6-6 REHABILITATION SERVICES 410 IAC 15-1.6-6(b)</p> <p>(b) The services shall be under the direction of a physician qualified by training or experience and supervised by a qualified person or persons. Based on document review and interview, the hospital failed to have the rehabilitation services under the direction of a physician qualified by training or experience.</p>	S001906	<p>2014. Brett Webb, Director of Facilities, will be responsible for requesting a Fire Inspection annually.</p> <p>Joel Stroud, the Director of IU Health Paoli Rehabilitation Services is in conversation with IU Health Bloomington Wylene Wyatts, Executive Director, to provide services under the</p>	05/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151306	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
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	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of hospital POLICY NUMBER: 1-103, entitled REHAB - REHABILITATION AND SPORTS MEDICINE, Medical Direction, reviewed 05/31/2012, indicated the Medical Director for IU Health Paoli Rehabilitation Services will serve as liaison to the rest of the medical staff and assure IU Health Paoli Rehabilitation Services provides quality patient care. 2. Review of the credential file of the Medical Director, MD#5, indicated there was no documentation of training or experience of this physician in the field of physical medicine or orthopedics. 3. In interview, on 3-25-14 at 2:30 pm, employee #A3 confirmed the above and no other documentation was provided prior to exit. 		<p>direction of a physician qualified by training and experience to become the Medical Director of IU Health Paoli Rehabilitation Services. Joel Stroud, Director of IU Health Paoli Rehabilitation Services is responsible for obtaining the physician direction and will maintain this relationship. 5/6/14 Draft Agreement received from the CMO at IU Health Bloomington. The agreement for the Medical Director for Rehab Services will be an agreement between IU Health Southern Indiana Physicians and IU Health Paoli.</p>		