

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2015
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NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
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S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 9/8/2015 through 9/10/2015 Facility Number: 003776 QA: cjl 09/17/15	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 document review, observation and staff interview, the facility failed to ensure a safe environment for patients by checking supplies to prevent outdated usage, by following manufacturer's directions and by ensuring all areas on patient care units were clean and sanitary. Findings included:	S 0554	1.& 2. Formula Outdated: A daily check of the expiration date has been added to the night nurse audit tool. This audit will include checking for date and time of opening the formula to ensure that it does not go past the manufacturer's expiration date. These audits will be completed for one quarter and then the plan will be reevaluated. The nightshift coordinator and charge nurse will be responsible for maintenance	09/29/2015

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.

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	<p>1. During the tour of the Pediatric Unit at 10:35 AM on 09/09/15, accompanied by staff members #7, the Chief Nursing Officer, and #8, the Unit Director, 2 of 2 cans of Similac powder infant formula with open dates of 05/11/15 and 06/09/15 and 1 of 3 cans of Enfamil powder infant formula with an open date of 07/01/15 were observed in the cabinet in the supply room. Manufacturer's label directions indicated the formula was to be discarded 30 days after opening.</p> <p>2. At 10:45 AM on 09/09/15, staff member #24, a nurse on the Pediatric Unit, indicated the can was dated when opened and he/she thought it was good for a month, but indicated the supply person checked for outdates.</p> <p>3. During the tour of the Med/Surg 3 Unit at 11:00 AM on 09/09/15, accompanied by staff members #7 and #28, the Unit Charge Nurse, the following observations were made:</p> <p>A. The microwave in the patient nourishment room was heavily soiled with dried food particles.</p> <p>B. One bottle of Jevity Tube Feeding was on the edge of the handwashing sink in the well-lit nourishment room.</p> <p>C. The floor of the soiled utility room was dirty and littered with scraps of paper, two heavily soiled flower vases</p>		<p>of the audit tool, ensuring its daily completion, and monitoring ongoing compliance.</p> <p>3A. & 5. Microwave ovens and Soiled Utility rooms will be sanitized by the housekeeper on the assigned units daily. This process will be discussed with housekeeping staff in daily huddles. This process will also be discussed in daily huddles with nursing staff so that they will also be responsible for cleaning the microwave after each use and discarding any unwanted patient items. The EVS managers will now round daily to inspect microwave ovens in soiled utility rooms to ensure microwaves are being cleaned and utility rooms are sanitized properly. The Environmental Services Director is responsible for monitoring and ensuring ongoing compliance. 3B. Nursing will be educated in daily huddles and staff meetings about ensuring all tube feeding formula which is sensitive to light, will be stored in cabinets until patient use. Dietary staff will monitor dietary areas on every unit to ensure feedings are in cabinets and not out exposed to light. Director of Dietary Services is responsible for monitoring and ensuring ongoing compliance. 3C. Soiled Utility rooms will be sanitized daily by the housekeeper on the assigned unit. Special attention will be paid to trash cans (trash bags and linen bags secured) to eliminate</p>				

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S 0612 Bldg. 00	<p>were on the counter, and gnats were flying around the trash can.</p> <p>4. Manufacturer's label directions on the Jevity bottle indicated the solution contained light sensitive nutrients and should be stored in a dark area or the shipping container.</p> <p>5. During the tour of the Med/Surg 2 Unit at 11:45 AM on 09/09/15, accompanied by staff members #7 and #27, the Unit Manager, the microwave in the patient nourishment area was observed heavily soiled with dried food and paper material.</p> <p>6. At 4:15 PM on 09/09/15, staff member #7 indicated the microwave cleaning was supposed to be done daily by the environmental services staff, but indicated there was no policy or documentation regarding this practice.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control</p>		gnats that are attracted to wet and sticky surfaces. Used patient care items, such a flower vases will be disposed of daily. See 3A. The Environmental Services Director is responsible for monitoring and ensuring ongoing compliance. Regarding all the deficiencies above related to outdated formula, microwave oven cleanliness, soiled utility room cleanliness, and tube feeding formula being stored properly; all items have been added to the safety inspection sheet for departmental safety rounds that members of the Executive Environment of Care Committee complete each month as well.				

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	<p>program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling. Based on observation, document review and staff interview, the hospital failed to ensure the clean linens and mop heads in the receiving clean storage room were stored in a clean and sanitary environment.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 1:47 PM on 9/9/2015, the clean linen storage holding room was observed with two carts uncovered storing blue gowns and clean fiber mops under the ceiling that was caked with dust, dirt and other soil debris. IU West Hospital Linen Handling and Storage policy (last reviewed April 2015) indicated all clean linens stored in the receiving area must be covered and protected from dust and other contaminants. At 3:05 PM on 9/9/2015, staff 	S 0612	Two linen cart covers were ordered and are now in place (9/28/15) to cover loose blue scrub uniforms and microfiber mops. Daily audits in linen storage room will be conducted to ensure that the standard is being followed. The Linen Tech and the EVS Manager will check these daily. The EVS Director will be responsible for monitoring audits and ensuring ongoing compliance. The overhead ceiling that was "caked with dust, dirt and other soil debris" has actually been confirmed by the Facilities Director to be required fire-proofed coating that protects our structural beams so that cannot be cleaned off.	09/29/2015			

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S 0912 Bldg. 00	<p>member #2 (Clinical Excellence Director) indicated all clean linen should be protected by covering or another effective means to protect clean linen and laundry from dust and other contaminants.</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 to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job</p>			

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	<p>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 and interview, the nurse executive failed to ensure pain assessments and reassessments were done according to policy and protocol for 7 of 11 inpatients who received pain relief interventions (#N1, N3, N9, N11, N20, N22 and N24) and for 2 of 5 inpatient pediatric patients (#N15 and N19).</p> <p>Findings included:</p> <p>1. Review of the facility policy "Pain Management", effective July 2014, indicated, "I. PURPOSE: All patients have the right to appropriate assessment and management of pain. ...Pain Intensity Levels: ...Moderate pain: self report of 4-6 on a 0- 10 numeric pain scale, Severe pain: self report of 7- 10 on a 0- 10 numeric pain scale. ...VI. PROCEDURE: A. Pain Assessment: 1. Assessment of the presence or absence of pain, specific</p>	S 0912	<p>A Pain team publication specific to the need for pain initial assessment, intervention, and reassessment will be distributed to each unit/area. Pain team members have assisted with the development of Tidbit publication and its distribution to staff in huddles and staff meetings. The Pain team publication is titled "Pain Tidbits." RN Patient Activity List (PAL) timeframes will be reset from 12 hours to 24 hours so that the RN can see tasks for assessment and reassessment with handoffs. All staff PAL and task lists will have a set timeframe from 0000-2359 to ensure that tasks regarding pain reassessment are not missed with caregiver hand-off. 10 random chart audits for pain management will be performed per unit/area per month for one quarter and audit plan/interventions will then be reassessed based on results. The first month of audits will be turned in to Regulatory/Quality office for</p>	10/16/2015

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	<p>to the growth and development of the patient, is done upon admission/entry into the system. ... C. Pain Reassessment: 1. The frequency of reassessment should be individually based on pain level and the patient's comfort-function goal. 2. For both pharmacological and non-pharmacological pain interventions, effectiveness of the intervention is evaluated through reassessment. ... 4. If upon reassessment, the patient's pain is not reduced, relieved, or at their comfort-function goal; implement additional interventions or contact the patient's practitioner. ... E. Documentation: 1. Pain assessment, comfort-function goal, pain interventions and patient/family education are documented in the patient's medical record."</p> <p>2. Medical record #N1 indicated a pain assessment score of 7 at 1600 hours on 04/29/15 with no documentation of any pain relief interventions although the pain goal of 3 was indicated in the care plan. Pain relief medication was given at 0200 hours on 04/29/15, but no pain score was documented.</p> <p>3. Medical record #N3 indicated a pain assessment score of 2 at 0015 hours on 07/01/15 with pain relief medication administered, but no reassessment was</p>		<p>review no later than October 14th . Nursing leadership from each unit will be responsible for distributing and returning completed audits. IS team has provided fact sheet for distribution to staff on how to change Cerner PAL time range to 24 hours. The CNO will be responsible for ensuring chart audit completion and monitoring ongoing compliance.</p>				

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	<p>documented until 0850 hours on 07/01/15.</p> <p>4. Medical record #N9 indicated a pain assessment score of 5 at 1746 hours on 08/26/15 with pain relief medication administered, but no reassessment was documented. Medication was also administered at 1128 hours on 08/27/15, but no pain assessment or reassessment were documented.</p> <p>5. Medical record #N11 indicated pain relief medication was administered at 1353 hours on 05/15/15, but no pain score was documented and no reassessment was documented until 2000 hours on 05/15/15.</p> <p>6. Medical record #N20 indicated a pain assessment score of 3 at 0000 hours on 04/04/15 with pain relief medication administered, but no reassessment was documented until 0400 hours on 04/04/15. Medication was also administered at 2000 hours on 04/04/15 for a pain score of 7, but no reassessment was documented until 2325 hours on 04/04/15.</p> <p>7. Medical record #N22 indicated a pain assessment score of 10 at 1159 hours on 07/26/15 with pain relief medication administered, but no reassessment was</p>			

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	<p>documented until 1824 hours on 07/26/15. Medication was also administered at 0400 hours on 07/30/15 for a pain score of 5, but no pain reassessment was documented until 0759 hours on 07/30/15.</p> <p>8. Medical record #N24 indicated cold therapy was applied to the right knee at 0331 hours on 05/08/15 for a pain score of 5, but no reassessment was documented until 0800 hours on 05/08/15.</p> <p>9. At 11:30 AM on 09/10/15, staff member #1, the Regulatory/Compliance/Accreditation Coordinator, confirmed the medical record findings and indicated that even though the facility policy no longer specified a time frame for pain reassessments, the expectation was for a reassessment to be done within an hour of an intervention.</p> <p>10. Review of the facility policy "Nursing Assessment of the Pediatric Patient", effective January 2014, indicated, "G. Pain assessments will be documented upon admission and every 4 hours thereafter. When pain medication or alternative treatment is administered, a reassessment will be documented no later than one hour after the intervention."</p>						

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	<p>11. Medical record #N15 indicated the patient was a 13 month old admitted through the (ED) Emergency Department on 04/15/15 for cough and congestion, but the record lacked documentation of a pain assessment while in the ED.</p> <p>12. Medical record #N19 indicated the patient was a 16 month old admitted through the ED on 05/10/15 for bronchiolitis, and the record indicated a pain score of 3 at 1100 hours on 05/10/15. Documentation indicated the pain site was mouth/oral and medication was given; however, the medication, Ibuprofen, was ordered for fever and was documented as given for fever. No reassessment was documented until 1500 hours on 05/10/15. Ibuprofen was documented as given for fever at 0026 hours and 0809 hours on 05/11/15, but the record lacked documentation that the patient had any fever while hospitalized.</p> <p>13. At 11:30 AM on 09/10/15, staff member #1, confirmed the medical record findings and indicated a pain assessment should be done on all patients upon entry to the system which included the ED. He/she confirmed the medication for patient #N19 was ordered for fever, not pain, and confirmed there was no documentation of any fevers for</p>			

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S 0952 Bldg. 00	<p>the patient.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, document review and staff interview, the facility failed to follow approved medical staff policy/procedure.</p> <p>Findings include:</p> <p>1) Review of a policy/procedure titled: "IU West Hospital, Policy #: HM 1.01, BLOOD and BLOOD COMPONENT ADMINISTRATION, V. PROCEDURES B. Minimum Documentation Requirements, 1. Pre-transfusion Vital Signs: between 1 and 60 minutes prior to initiating the transfusion (Start time) take and record</p>	S 0952	A unit-based blood slip competency was developed and distributed by unit leadership to reinforce key concepts when completing a pre/intra/post transfusion assessment. Blood administration records will be checked by each charge nurse or shift coordinator for corrections/approval on each shift on each unit before being sent to the blood bank. The blood bank will send the Regulatory/Quality Dept compliance numbers for blood administration records each week in the form of an audit. The Regulatory/Quality dept will send out the data weekly to each dept's appropriate manager for follow-up. This information will also be shared in October's	10/16/2015

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S 1118 Bldg. 00	<p>vital signs including: temperature, heart rate, respiration and blood pressure.</p> <p>2. 15 Minutes Vital Signs: between the first 10 and 20 minutes of the transfusion, take and record vital signs including: temperature, heart rate, respirations and blood pressure.</p> <p>4. Post transfusion Vital Signs: take and record post- transfusion vital signs including: temperature, heart rate, respiration and blood pressure."</p> <p>2) Review of transfusion records: T(Transfusion) # 1 through 7 revealed T#5 had a recorded start time of 2210 but a Pre vitals time of 2215 which indicates Pre Vitals were taken after the start of the transfusion instead of before the transfusion.</p> <p>3) On 8/9/15 at 11:30 a.m. staff person CP15 acknowledged the approved Transfusion Administration Policy was not followed for T#5.</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</p>		<p>Leader's forum meeting as well as house-wide CPC and Regulatory Readiness meetings. The managers will follow up with staff members individually if there are any issues or required items for correction. The Director of Clinical Excellence will be responsible for the ongoing plan and ensuring compliance.</p>		

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	<p>hazard to patients, public, or employees.</p> <p>Based on observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in the Compressed Gas Storage Room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. IU West Hospital Compressed Gas and Oxygen Use policy (last reviewed December 2013) stated, "Cylinders must be secured at all times so they cannot fall." 2. At 1:20 PM on 8/9/2015, the bulk oxygen storage room was toured. There were 10 tall Nitrogen cylinder tanks and 3 tall Helium cylinder tanks not secured and were standing upright. The chain that secures the cylinders was lying on the floor. 3. At 1:25 PM on 8/9/2015, staff member #39 (Receiving Staff Member) indicated the vendor delivered the canisters earlier in the morning and they never chained the canisters. The staff member indicated he/she didn't follow through to see if the vendor had chained the cylinders. 	S 1118	<p>Praxair was notified concerning the incident involving a substitute driver leaving the tanks unsecured. Praxair is now conducting weekly safety meetings which include this subject. Facilities staff are inspecting the medical gas storage room three times a day (once per shift) to ensure all tanks are secure. The inspections are documented on an inspection log. A "tanks secure" column is being added to the log sheet to call attention to this matter and to document that this safe condition has been verified. These audits will be completed for one quarter then a plan for continuing the audits will be discussed and implemented. Facility services Director is responsible for the ongoing deficiency correction.</p>	09/25/2015			

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NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S 2104 Bldg. 00	<p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8(a)</p> <p>(a) If the hospital provides inpatient or ambulatory surgical services, the services shall meet the needs of the patients served, within the scope of the service offered, and in accordance with acceptable standards of practice and and safety. Based on documentation review, observation, and staff interview, the facility failed to ensure the six operating rooms met the required temperature as defined by hospital policy and American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines.</p> <p>Findings included:</p> <p>1. Indiana University Health IUHAC Preoperative Services Guidelines for Temperature, Humidity, and Air Handling (last reviewed July 2013) indicated the daily monitoring of the operating room temperature to be maintained between 68 and 73 degrees Fahrenheit and the relative humidity to be maintained from 20% to 60%. The policy references ASHRAE guidelines</p>	S 2104	The OR temperature parameters have been reset to 68-75 degrees F (in line with AORN/ASHRAE standards) in the Building Management System (BMS). Humidity in all OR rooms will be monitored and kept within 20-60%. The temperatures in the BMS system will be set according to policy. The temperatures and humidity are logged daily and monitored weekly by Facilities staff. The set parameters will be locked out from end user control. Facility Services Director will be responsible for ongoing monitoring and compliance.	09/24/2015			

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	<p>regarding to temperature and humidity.</p> <p>2. AORN (Association of periOperative Registered Nurses) supports the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on temperature and humidity ranges for perioperative settings. The operating rooms' temperature range should be between 68 F and 73 F, while the humidity should be between 30% and 60%.</p> <p>3. Staff member #5 (Vice President of Operations) provided documented evidence for 6 operating rooms' temperature and relative humidity dated from September 1, 2015 to September 7, 2015. The documentation evidenced a consistency that the operating rooms were registering below 67 degrees Fahrenheit and the relative humidity level exceeded 60% over half of the recorded period. The average temperatures of the 6 operating rooms were approximately 64 degrees Fahrenheit.</p> <p>4. At 1:50 PM on 9/8/2015, Operating Room #2 was toured with staff member #9 (Surgical Service Director). The thermostat for the room was set at 65 degrees Fahrenheit.</p>			

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	<p>5. At 1:55 PM on 9/8/2015, staff member #14 (Operating Room Manager) indicated the operating room temperature and relative humidity guidelines are 68 to 72 degrees Fahrenheit and 20% to 60% respectively.</p> <p>6. At 2:55 PM on 9/8/2015, staff member #5 (Vice President of Operations) confirmed the electronic temperature readings of the six operating rooms were consistently less than the required 68 degrees Fahrenheit.</p>				