

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150051	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W SECOND ST BLOOMINGTON, IN 47403
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 5/6/2013 through 5/9/2013</p> <p>Facility Number: 005047</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 05/15/13</p>	S000000		
S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection</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>control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation and interview, the infection control committee failed to ensure the Behavioral Health Unit and the off-site Anticoagulation Clinic were cleaned and disinfected according to acceptable standards of practice.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the Behavioral Health Unit at 1:45 PM on 05/07/13, accompanied by staff members A5 and A48, four rectangular light panels were observed in the ceiling of the crisis nourishment room. Two of the panels were observed with a scattering of black material/bugs, and one panel had a heavy concentration of the black material/bugs. At 9:45 AM on 05/09/13, the unit director, staff member #A47, confirmed the panels contained ladybugs. During the tour of the off-site Anticoagulation Clinic at 11:05 AM on 05/08/13, accompanied by staff members A50 and A55, a heavy layer of dust/soil was observed on the refrigerator, the ledge near the centrifuge, and the ledge around the sink in the lab draw room. 	S000596	<p>Tag: S 596 Finding(s): 1-2</p> <ol style="list-style-type: none"> Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): The 4 rectangular light panels in the ceiling of the crisis nourishment room have been cleaned out of bugs and debris. This took place on 5/21/13. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): The housekeeper, who has ownership of this unit Monday-Friday, will keep a log on the lights that have insects and debris. It will also be added to the Environment of Care checklist when rounding in all departments/units throughout the hospital. Responsibility (no specific employee names, title(s) only): Environmental Services Supervisor Implementation Date (By 	06/09/2013

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	<p>Staff member #A56 was observed drawing blood from a client and not disinfecting the chair and arm support before drawing blood from another client.</p> <p>4. Staff member A55 indicated the center did notify the contracted cleaning company about dusty window sills.</p>		<p>what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases):</p> <p>The correction has been made (5/21/13) and the prevention strategy is in place. Tag: S596, Findings: 3 & 4</p> <p>1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction):</p> <p>Met with GSF about the cleaning practice. They are going to monitor cleaning more closely to meet our expectation. Revised our phlebotomy policy to state: "Clean phlebotomy chairs between patients".</p> <p>2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?):</p> <p>We will perform random checks to make sure that cleaning by GSF is satisfactory. We have added monthly safety check to include observing phlebotomists cleaning phlebotomy chairs between patients.</p>	

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S000610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p>		<p>3. Responsibility (title only): Phlebotomy team lead, Outreach team lead, and Lab safety officer</p> <p>4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): June 9, 2013</p>	

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	<p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation, manufacturer's labeling, and interview, the infection control committee failed to ensure staff prepared frozen dinners and stored nutritional supplements according to labeling instructions and the ISDH Retail Food Establishment Sanitation Requirements.</p> <p>Findings included:</p> <p>1. During the tour of the obstetrical area at 9:30 AM on 05/07/13, accompanied by staff members A5, A15, and A16, a sign on the refrigerator on the post-partum unit indicated new Marie Callendar and Hungry Man frozen dinners were available for the patients. The manufacturer's directions on the frozen dinners indicated the internal temperature of the food needed to reach 165 degrees Fahrenheit (F) before serving.</p> <p>2. A nurse on the unit, staff member A17, indicated the meals were prepared for moms who delivered late and were hungry. He/she indicated the meals would be heated according to package directions, but staff did not have a food thermometer in the kitchen and did not test to ensure the food reached 165 degrees (F).</p>	S000610	<p>Tag: S 610 Finding(s) 1 & 2</p> <p>1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Discontinued use of frozen meals for patients on 5/29/2013/ 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): a. Refrigerator posting informing staff no frozen meals b. Email to supervisor food services of changes requesting she inform staff 3. Responsibility (title(s) only): Clinical Director 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): 5/29/2013 Tag: S 610 Finding(s): 3, 4, 5</p> <p>1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction):</p> <p>All IP nursing units will have an identified covered cabinet in the nourishment center for Tube Feedings. A complete list will be supplied to the diet office for their information.</p>	06/01/2013

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S000612	<p>3. During the tour of the Intensive Care Unit at 11:10 AM on 05/07/13, accompanied by staff members A5, A18, and A19, seven containers of Abbott supplemental tube feedings were observed stored on an open counter in the nourishment area. Labeling indicated the solutions contained light sensitive nutrients.</p> <p>4. During the tour of the 4 North Unit at 1:45 PM on 05/07/13, accompanied by staff members A5 and A49, two containers of Abbott supplemental tube feedings were observed stored on an open counter in the nourishment area and one container was observed stored on an open counter in the med room. Labeling indicated the solutions contained light sensitive nutrients.</p> <p>5. An information sheet from January 1, 2013, provided by Abbott, indicated, "Store product in the shipper as long as possible or store on covered shelves or in a closed cabinet prior to use."</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</p>		<p>2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?):</p> <p>When dietary delivers the product to the unit it will go directly into these marked cabinets.</p> <p>3. Responsibility (no specific employee names, title(s) only):</p> <p>Clinical Director of each unit</p> <p>4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases):</p> <p>June 1, 2013</p>	

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	<p>and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure there were written laundry policies regarding the handling and processing while being laundered in the Laundry Department.</p> <p>Findings included:</p> <p>1. At 1:20 PM on 5/7/2013, the Laundry Department was toured. The Laundry Department was at an offsite location from the hospital where the soiled laundry and linen are washed, dried, pressed, and folded before they are transported back to the hospital. The hospital employees were observed in the Laundry Department processing</p>	S000612	<p>Tag: S 612 Findings: 1 - 31. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response:</p> <ul style="list-style-type: none"> ·Developed a Linen Services Policy for cleaning the finishing side of the laundry in the laundry area. ·Made a tray that will sit in front of the Braun Theta Folder that will be disinfected daily. The ends of the linen items being processed must rest on the tray when placing them on the folder. Any linen item that touches the floor must be placed in the rewash barrel. This process was implemented on May 22, 2013. ·Effective May 9, 2013, all Linen Health Care Workers (LHCW) were mandated to wear shoe covers on the finishing side in the laundry area. ·As of May 9, 2013, the floor is mopped using a disinfectant once a day in front of the Chicago Edge spreader feeder, Chicago 	05/30/2013

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	<p>hospital sheets in equipment that mechanically presses and folds them before they are transported back to the hospital. The hospital staff were observed allowing the clean sheets to drag on the concrete floor while they were fed into the processing equipment by staff at two separate processing stations. The cement floor that the sheets were dragged on was observed with debris, dirt, and other soil residue on it.</p> <p>2, The Indiana University Health Bloomington Hospital Infection Control policy #8-165-2 (last reviewed 8/7/2012) references the handling of linen while in the hospital. The policy does not reference the handling, processing, and transporting of clean and soiled linen while in the off-site hospital's Laundry Department.</p> <p>3. At 9:30 AM on 5/9/2013, staff member #34 indicated the hospital does not have a policy on the sanitation practices of the off-site</p>		<p>Air XL and the Braun Sigma folders at the beginning of the shift. On May 21, 2013, a log sheet was implemented to document the required disinfection process.</p> <p>2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: · Monitor and observe that all LHCW on the finishing side follow the mandated procedures listed above.</p> <p>3. Responsibility (title(s) only): Linen Services finishing side Lead, Linen Services Coordinator, Maintenance Tech III, Bio-Med Tech II and Linen Services Manager. Response: · Linen Services Finishing Side Lead is responsible to observe all LHCW's performing job duties on the finishing side wear shoe covers. · Linen Services Lead responsible for ensuring the floor is disinfected in front of the three folders and Chicago Edge daily. · Linen Services Coordinator and or Linen Services Manager will monitor that the sign off sheets are completed on a daily basis. · Linen Services Manager and Infection Control will develop the finishing side policy. · Maintenance Tech III and Bio-Med Tech II fabricated a "tray" to act as barrier between the linen and the floor for the Theta Folder.</p> <p>4. Implementation Date (By what date are you going</p>				

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S000732	<p>Laundry Department. The staff member confirmed the practice that was observed on 5/7/2013 was not sanitary for handling of clean linen.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based on medical record review and interview, the facility failed to accurately document the course of treatment for one of two newborn infants whose records were reviewed (#N4).</p> <p>Findings included:</p> <p>1. The medical record for infant #N4, born at 9:10 AM on 12/11/12, indicated a consent for a circumcision signed by the parent at 1330 on 12/11/12. The record also contained admission information indicating the parent wanted a baby boy</p>	S000732	<p>to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: · Developed a new policy for the laundry area to include the process for clean linen. The Infection Prevention Committee approved the policy (attached) on May 30, 2013 for immediate implementation.</p> <p>Tag: S 732 Finding(s) 1 and 2 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): a. (1. Circumcision) – i. Add item to clinical documentation as follows: 1. Circumcision Procedure not performed for the following reason(s) a. Mom changed her mind b. Delayed until post discharge c. Contraindicated due to clinical condition ii. Education for staff and pediatricians regarding procedure documentation changes. iii.</p>	05/30/2013

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	<p>circumcised. An "Abstract Summary Form" indicated a principal procedure as circumcision with the date of 12/12/12 and the physician's name. The only physician exam of the infant was at 0710 on 12/12/12 and did not reference circumcision. The 4-page printed "Physician Discharge Orders" were signed as a telephone order from the physician at 0911 on 12/12/12 and electronically signed by the physician at 0858 on 12/17/12. The pages were not completed, including the box to indicate an actual discharge order. The record lacked any record of the circumcision being performed, any follow-up or observations if it was done, any documentation of if it was not done, or any discharge instructions regarding a circumcision to the parents.</p> <p>2. At 1:15 PM on 05/08/13, staff members A15, A16, A74, A75, and A76 confirmed the findings.</p>		<p>Audit 30 of male newborns through HPF for the following 1. Mom's request for circumcision 2. Presence of consent for circumcision a. With all signatures, date/time present 3. Documentation of procedure if done 4. If no procedure documented, documentation of reason for not performing procedure. b. (2. Discharge Order) – i. Developed population specific discharge order form. Currently in form approval process. ii. Once form approved, staff and pediatrician education will occur. iii. Audit 30 newborn charts through HPF for the following: 1. To evaluate that all elements are complete on discharge orders 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): a. (Circumcision) Repeat audit 90 days following completion of first audit. b. (Discharge Orders) Repeat audit 90 days following completion of first audit. 3. Responsibility (title(s) only): Clinical Director and Executive Director 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Circumcision – a. New documentation build completed by 5/30/13 b. Documentation change</p>		

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S000744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on medical record review, policy and procedure review, and interview, the facility failed to ensure all forms were accurate, completely filled out, and corrected according to policy for 9 of 17 closed patient records reviewed (#N1, N2, N3, N6, N9, N11, N12, N14, and N15).</p>	S000744	<p>communicated to staff by email on 5/30/13 c. Assess staff received education on 6/30/13 d. Follow-up with staff who have not completed education by 7/15/13 e. Begin chart audit 7/15/13 and complete when 30 male infants with moms desiring that infant be circumcised have been audited. Discharge Orders f. Anticipate form approval by 7/1/13 g. Documentation change communicated to staff by email on 7/1/13 h. Assess staff received education on 7/29/13 i. Follow-up with staff who have not completed education by 8/12/13 j. Begin chart audit 7/12/13 and complete when 30 newborn charts have been audited for discharge orders (and chart has the new population specific discharge orders on it)</p> <p>Tag: S 744 Finding(s): 1-3 Discharge after Death Checklist 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: Modify the Discharge after death checklist with regard to valuables and belonging add checkbox that</p>	07/01/2013

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. The Discharge After Death Checklist from 11/12/12 for patient #N1 was incomplete regarding the embalming permit. 2. The Discharge After Death Checklist from 02/24/13 for patient #N2 was incomplete regarding the embalming permit, valuables and belongings, and time to morgue. 3. The Discharge After Death Checklist from 01/16/13 for patient #N3 was incomplete regarding the embalming permit. 4. The first page of the Consent to Medical/Surgical Services/Special Procedures for patient #N6 was incomplete regarding date, time, and physician name. Another Anesthesia Informed Consent, dated 10/01/12 at 0948, lacked a physician name and type of anesthesia on the first page. 5. At 1:45 PM on 05/08/13, staff member #A15 indicated the patient did not receive anesthesia and the physician's name would have been filled in if it was given, but confirmed the consent was already signed without being complete. 		<p>states sent to morgue with body. Add checkbox to current area to write name of person belongings given to. Build a Midas focus study regarding completion of Discharge after death checklist.</p> <ol style="list-style-type: none"> 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: Will complete a Midas focus review audit of Death after Discharge checklists. Review 10 per month by the PCD's. Individual education to follow any omissions, corrections or improvements notified. Will also send email communication to all nurses regarding form completion. 3. Responsibility (no specific employee names, title(s) only): Response: Patient Care Directors 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: June 24, 2013 <p>Tag: S 744 Finding(s) 4,5, 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Epidural Consents – a. Identify anesthesiologist doing the epidural and fill out the consent form in its entirety before patient signs the consent and it is witnessed. b. Re-education of</p>				

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	<p>6. The Anesthesia Informed Consent for patient #N9, a child, was signed by a parent, but lacked a date, time, and witness signature in the spaces indicated. The Anesthesia Record lacked documentation of date, ASA classification, surgery start time, and surgery end time.</p> <p>7. The Chest Pain Discharge Instructions from 03/08/13 for patient #N11 was incomplete regarding discharge medications. The Blood Bank Pick Up Card from 03/08/13 had the time marked out/changed.</p> <p>8. The Blood Administration Profile from 02/27/13 for patient #N12 had the times for pretransfusion vital signs and start time written over/changed. Another Blood Administration Profile from 02/27/13 lacked documentation that the consent was signed and on the chart and the name of the ordering physician. A Blood Administration Profile from 03/02/13 had the start time and the time for the 15 minute vital signs written over/changed. The Blood Bank Pick Up Card from 03/02/13 had the time marked out/changed.</p> <p>9. The Patient Discharge Instructions for patient #N14, who had an access port</p>		<p>staff regarding importance of completing the consent in its entirety. 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): a. Audit 30 charts after re-education complete b. Re-audit 90 days following completion of 1st audit. 3. Responsibility (title(s) only): Clinical Director and Executive Director 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases):</p> <p>1.Re-education of staff will be complete by July 1, 2013 2.Chart will be complete by August 1, 2013 3.Re-audit 90 days following completion of 1 st audit. Tag: S 744 Finding(s): 6</p> <p>1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction):</p> <p>Response: 1) Anesthesia Record is being revised by the compliance officer from the Anesthesia Group. The revision will address duplication of information on multiple forms. 2) Revision of Universal Protocol</p>	

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	<p>inserted, lacked any instructions regarding the port, a dressing, or bathing instructions. The Consent for Blood/Blood Products Transfusion from 03/24/13 indicated "Verbal" underlined with 2 witnesses, but did not indicate a name of who gave the verbal consent, the patient or someone else.</p> <p>10. The Blood Administration Profile from 03/28/13 for patient #N15 had the start time and the time for 15 minute vital signs written over/changed.</p> <p>11. The facility policy "Consent: General and Informed", last revised 08/03/11, indicated, "Informed consent is the process in which the physician or other individual performing the procedure/treatment provides adequate information for the patient or patient's appropriate representative to make an informed decision on the proposed treatment or procedure. ...At a minimum, this information should include the following: ...Identify the physician or licensed independent practitioner, as delegated by the physician, doing the procedure. ...Each informed consent should include the following if appropriate: ...Name of the patient or the patient's appropriate representative. Date and time the informed consent form is signed by the patient or the patient's</p>		<p>Safe Surgery Checklist completed on 1/30/13. New form was available 2/15/13. This new checklist assures that all required documents are completed as required.</p> <p>3) Re-education of staff to assure that anesthesia consent is complete prior to documenting is on Universal Protocol Safe Surgery Checklist.</p> <p>2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?):</p> <p>Response: 1) We will do a focus study for six months to monitor completion. Action plan will be done based on audit results.</p> <p>3. Responsibility (no specific employee names, title(s) only):</p> <p>Response: Executive Director Perioperative Services, Clinical Director Pre - Op, Nurse Manager of Pre - Op and Clinical Director of Surgery and Holding Room nurse.</p> <p>4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases):</p>	

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	<p>appropriate representative. Signature of the person witnessing the consent."</p> <p>12. The facility policy "Correction of Mistakes in Clinical Records", last revised 05/28/12, indicated, "Procedure: 1. To correct a mistaken entry on a non-computer generated document: a. Draw a single line through the entry and write 'mistaken entry'. Include date and initial. b. Write the correction."</p> <p>13. At 9:00 AM on 05/09/13, staff member A74 confirmed the medical record findings.</p>		<p>Response: Immediate correction expected with education of staff. Continued auditing will be done using the Focus Study. Tag: S 744 Finding(s): 8 and 10</p> <p>1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction):</p> <p>Response: Change the policy Correction of Mistakes in the Clinical Record to read "for non-computer generated documents where there is not enough blank space to appropriately document correction, the employee will strike out mistaken entry and initial. At the bottom of the form the employee will initial and make correction.</p> <p>2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?):</p> <p>Response: Add to the current method of auditing BAP's. Are any entrée's overwritten without proper documentation. All found entries will be forward to the employee's director for individual employee follow up.</p> <p>3. Responsibility (no specific employee names, title(s) only):</p>	

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			<p>Response: Blood Bank technologist and unit clinical directors</p> <p>4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases):</p> <p>Response: June 15, 2013 Tag: S 744 Finding(s) 10</p> <p>1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction):</p> <p>a. Re-educate staff regarding appropriate means of changing written documentation in a paper medical record</p> <p>2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?):</p> <p>a. Audit 30 charts after re-education complete</p> <p>i. Review hand written documentation for errors corrected.</p> <p>b. Re-audit 90 days following completion of 1st audit.</p> <p>3. Responsibility (title(s) only):</p>	

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S001014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on observation, interview, and policy and procedure review, the facility failed to follow its pharmacy policy regarding multidose medications.</p> <p>Findings included:</p> <p>1. During the tour of the pre-operative area at 2:40 PM on 05/06/13,</p>	S001014	<p>Clinical Director and Executive Director</p> <p>4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases):</p> <p>1.Re-education of staff will be complete by July 1, 2013 2.Chart will be complete by August 1, 2013 3.Re-audit 90 days following completion of 1 st audit.</p> <p>Tag: S1014 Finding(s): 1, 2 and 5 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: 1) Investigating viable alternative for multidose vials of Lidocaine in the OR environment. Pharmacy is looking at pre-filled syringes as option. 2) Staff reminded at</p>	05/30/2013

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	<p>accompanied by staff members A5 and A20, one of one 20 milliliter (ml.) vial of Xylocaine 1% and one of one 20 ml. vial of Xylocaine 2% were observed open, but not dated, in a drawer of a cart in the med room.</p> <p>2. Staff member A20 indicated the vials should not be stored there and should be dated if used as a multi-dose vial.</p> <p>3. During the tour of the off-site Pain Center at 8:50 AM on 05/08/13, accompanied by staff members A50, A51, and A52, an open, but not dated, vial of Tubersol was observed in the medication refrigerator.</p> <p>4. Staff member A52 indicated the medication was used for staff TB testing in February.</p> <p>5. The facility policy "Multidose Solutions and Products", last revised 04/15/11, indicated, "1. All opened multidose solutions are to be disposed of twenty eight (28) days after the vial is opened or the manufacturer's expiration date, whichever occurs first. 2. The staff member will write the date opened on the vial when it is not dated by the pharmacy."</p>		<p>huddles to discard multidose vials at end of each case. 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: 1) Observations during daily OR rounds with Charge Nurse 2) Holding room nurses will do daily checks of medication cart in PreOp area. 3. Responsibility (no specific employee names, title(s) only): Response: Executive Director Perioperative Services, Clinical Director Pre - Op, Nurse Manager of Pre - Op and Clinical Director of Surgery and Holding Room nurse. 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: Immediate correction expected. Concurrent observations will be conducted through September 1, 2013. Tag: ISDH S 1014 Finding(s): 3 - 5 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: 1. Multidose medication was disposed of during survey 5/8/2013 2. Review multidose medication policy with staff: 5/16/2013 3. Complete random checks for multidose medications quarterly. 2. Prevention strategy (How are</p>	

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p>		<p>you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: 1. The Pain Center does not use multidose medications. The multidose vial had been used for onsite TB testing and was an exception. 2. Complete quarterly checks of medications to assure no multidose vials are present. 3. Assure all TB vials are dated and disposed according to policy after TB testing is completed in 2/2014. 3. Responsibility (title(s) only): Response: Director of Rehabilitation and Pain Services 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: Deficiency corrected: 5/8/2013</p>		

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	<p>Based on observation, policy and procedure review, manufacturer's directions, and 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 five Departments: Clinical Engineering, Pharmacy, Laboratory, scope cleaning room and off-site pain center and four patient care areas.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Environment of Care policy #I-190 (last reviewed 5/25/2012) states, "The hospital environment is maintained in a safe, clean and orderly manner at all times." 2. At 9:45 AM on 5/7/2013, the Telemetry Room located within the Clinical Engineering Department was toured. The room was observed filled with assorted health care equipment. In rear of the room were electrical panels that could not be accessed. The large room had no aisles after entering the room. 3. At 10:50 AM on 5/7/2013, the Pharmacy Department store room was toured. The storeroom was observed with a low ceiling and approximately 	S001118	<p>Tag: S 1118 Findings: 1 & 2 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: Telemetry room was cleaned, properly arranged, an aisle created, and 3 feet of clearance was provided for the electrical panels. 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: Marking tape placed on the floor to define aisle and electrical panel clearances. This room has been added to the Electrical Room inspection list, to be observed at least annually. 3. Responsibility (title(s) only): Response: Clinical Engineering staff and Hospital Electricians. 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: This work was completed on 5/7/2013. Tag: S 1118 Finding(s): 3 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: Boxes and bins have been removed from the pipe. 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e.</p>	06/15/2013

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	<p>6-feet from the floor in some areas. Cardboard boxes of supplies and other miscellaneous items were stored on the sewer pipe and not on the shelves located under it.</p> <p>4. At 12:55 PM on 5/8/2013, the Microbiology Area was toured in the hospital Laboratory. A cabinet area located under a single bay sink was observed with a gray container under the drain line and a discolored towel was under the sink basin. The white towel was heavily soiled and had a rusty color to it.</p> <p>5. Environment of Care policy #1-189 (last reviewed 1/21/2013) notes that eye wash stations are to be where staff are working with chemicals for their safety. The policy references ANSI; Standards for Emergency Eyewash and Shower Equipment; and OSHA safety standards for Medical Services and First Aid.</p> <p>6. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such</p>		<p>monitoring, observation?): Response: Staff has been informed not to store anything on pipe and signs placed. 3. Responsibility (no specific employee names, title(s) only): Response: Pharmacy Manager 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: Corrected 5-13-2013 Tag: S 1118, Finding(s): 4 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: Maintenance removed the bucket and locked the cabinet. 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: Lab Safety Officer will perform routine inspection of all of the cabinets as a part of his safety check. 3. Responsibility (title): Safety officer of the lab Response: NA 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: Deficiency was corrected the day of the inspection. Tag: S 1118 Findings: 5 - 11 1. Plan of Correction (how</p>		

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	<p>sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>7. At 9:55 AM on 5/7/2013, the Clinical Engineering Department was toured. The Clinical Engineering Department was observed with acid batteries and concentrated disinfectant. The manufacturer label on the disinfectant requires 15 minutes of flushing of water if the chemical comes in contact with someone's eyes. The department did not have an eyewash station to meet the chemical and acid exposure.</p> <p>8. At 1:05 PM on 5/8/2013, the Laboratory Store Room was toured. The sink chemical prep station located in the room was observed with concentrated bleach and other chemicals that require 15 minutes of eye flushing with water if the chemical comes in contact with someone's eyes. The room did not have an eyewash station to meet the chemical exposure. 9. During the tour of the endoscopy area at 3:25 PM on 05/06/13, accompanied by staff members A5 and</p>		<p>are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: Permanent Eye Wash Stations to be installed in the following locations: -Clinical Engineering Department -Laboratory Storeroom -Endoscopy Scope Cleaning Room -Pain Center (off site location) 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: Readiness Rounding will emphasize the MSDS process to assure that staff is knowledgeable on the products they use. Hospital wide MSDS safety training will be completed for all Hospital staff by December 2013. 3. Responsibility (title(s) only): Response: Environment of Care Manager for Eye Washes. EOC Specialist and Department Heads for Product knowledge assistance. 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: Eye Wash Stations at 4 locations will be installed by June 9, 2013. Mixing cup and phone charger removed at Pain Center on May 8, 2013. Tag: S 1118 Findings: 12 - 19 1. Plan of Correction (how are you going to correct the deficiency? If already corrected,</p>	

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	<p>A22, the chemicals Aseptizyme and Cidex were observed in the scope cleaning room. Manufacturer's directions were to flush eyes 15 to 20 minutes if splashed with the chemical. Staff member A22 indicated they had a 32 ounce bottle of flush solution, but no eyewash station for a 15 minute flush.</p> <p>10. During the tour of the off-site Pain Center at 8:50 AM on 05/08/13, accompanied by staff members A50 and A51, a container of Virex 256 was observed on the counter of the storage closet. Manufacturer's directions were to flush eyes 15 to 20 minutes if splashed with the chemical. A plastic measuring container that was dusty and holding a pen and phone charger was also on the counter.</p> <p>11. Staff member A51 indicated a contracted cleaning service provided after hours cleaning and he/she was unsure of how the chemicals were mixed or used, but indicated there was no eyewash station available.</p> <p>12. During the tour of the Emergency Department at 8:45 AM on 05/07/13, accompanied by staff members A5 and A13, a Steris Amsco warming unit with upper and lower cabinets, was observed containing blankets for patient use. The</p>		<p>include the steps taken and the date of correction): Response: Procedures for Blanket and Fluid Warmers will be updated to make sure proper temperature is maintained. This is done through observation and adjustments to warming cabinet. When temperatures cannot be maintained after adjustments notify the Maintenance Department. The updated log and the updated policy/procedure will be distributed to all Departments with warmers via email. 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: Warmer temperatures will become a checklist item on routine Environment of Care Readiness Rounds. 3. Responsibility (title(s) only): Response: Department Managers & Directors 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: This work will be completed by June 15, 2013.</p>	

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	<p>temperature displays on the unit indicated the upper cabinet was 138 degrees Fahrenheit (F) and the lower cabinet was 133 degrees F. Review of the daily monitoring logs indicated the cabinets only registered 130 degrees F. or below nine days between 02/17/13 and 05/07/13. Documentation on the logs indicated "arrows or decreased" for all of the times the temperature was elevated.</p> <p>13. During the tour of the Oncology Department at 10:05 AM on 05/07/13, accompanied by staff member A29, a small Pedigo warming unit was observed containing blankets for patient use. The temperature display on the unit registered 150 degrees F.</p> <p>14. Staff member A29 indicated the department did not keep a temperature monitoring log.</p> <p>15. During the tour of the 4 North Unit at 1:45 PM on 05/07/13, accompanied by staff members A5 and A49, a small Pedigo warming unit was observed containing blankets for patient use. The temperature display on the unit registered 161 degrees F.</p> <p>16. Staff member A49 indicated the unit did not keep a temperature monitoring log.</p>						

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	<p>17. During the tour of the off-site Pain Center at 8:50 AM on 05/08/13, accompanied by staff members A50, A51, and A52, a small Pedigo warming unit was observed empty, but still warm, with no temperature displayed.</p> <p>18. Staff member A52 indicated the center did not keep a temperature monitoring log, but had been using the warmer for blankets for patients. He/she indicated the unit was turned off today because the temperature was registering 150 degrees F.</p> <p>19. The facility policy "Warming Cabinets for Blankets and Fluids", last revised 08/12/11, indicated, "4. Blankets are to be warmed in a chamber separate from the solution warming chamber. a. The blanket warming chamber should be limited to 130 degrees F. (54.4 degrees C). ...Procedure: ...3. The interior temperature of the chambers is to be logged each day of department operation. 4. For warmers out of range: a. Adjust the temperature up or down as needed. b. Recheck the temp in one hour. c. If still out of range, initiate an Engineering & Maintenance work request."</p>			

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S001162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</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, as follows:</p> <p>(A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on observation, document review and staff interview, the facility failed to comply with manufacturer recommendations for 2 of 2 Hydrocollators and failed to schedule preventive maintenance appropriate frequency for 2 Linear Accelerators.</p> <p>Findings included:</p> <p>1. Environment of Care policy #6-110 (last reviewed 5/9/2012) states, "All inventory of Medical</p>	S001162	<p>Tag: S 1162 Finding(s): 1 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: The Clinical Equipment Inventory for Hydrocollators was reviewed to make sure that all of the following information is included: PM Procedures; Test frequencies; Management information; Who services the device; along with Manufacturer and parts vendor information. 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: When reviewing</p>	06/15/2013

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	<p>Equipment, along with history of each device included in the program is maintained in the Clinical Engineering Department: PM Procedures; Test frequencies; Management information; Who services the device; and Manufacturer and parts vendor information."</p> <p>2. The Operation Manual instructions for the use and operation of the IU Rehabilitation & Sports Center's Hydrocollator M-1 and IU Health Bloomington Hospital Rehabilitation Department's Hydrocollator SS Master Heating Unit note the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 166 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs.</p> <p>3. The IU Rehabilitation & Sports</p>		<p>existing or creating new procedures/protocols for equipment make sure the EOC Medical Equipment inventory guidelines are followed. 3. Responsibility (title(s) only): Response: Clinical Engineering Supervisor 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: Hydrocollator inventory and procedures were reviewed and approved by the Clinical Engineering Supervisor May 9,2013.Tag: S 1162 Finding(s): 2-3 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: Completed 5/8/13. Researched current manufacturer specifications for temperature range. Altered monthly temperature tracking form to match current manufacturer specifications for temperature range. Temperatures exceeding 166 degrees Fahrenheit will initiate a call to Clinical Engineering to service the unit. The unit will be taken out of service until the temperature falls within the acceptable range. Staff will not use moist heat packs in patient care if the water temperature exceeds 166 degrees Fahrenheit. 2.</p>				

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	<p>Center's Hydrocollator M-1 April temperature log revealed the water exceeded 166 degrees Fahrenheit for 4 of 22 days (4/19, 24, 29, 30). The IU Health Bloomington Hospital Rehabilitation Department's Hydrocollator SS April temperature log revealed the water exceeded 166 degrees Fahrenheit for 25 of 26 days (4/1, 2, 4-6, 8-18, 20, 22-27,29-30).</p> <p>4. At 9:55 AM on 5/8/2013, the Radiation Oncology Center was toured. The Radiation Oncology Center was observed with two Linear Accelerators: IX1 and IX2. During the inspection, the manufacturer representative was observed servicing one of the two machines.</p> <p>5. The facility could not provide preventative maintenance schedules for the 2 Linear Accelerators. However, the computer documentation revealed IX1 previous 3 preventative maintenance inspections were</p>		<p>Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: Using standardized form for all locations. The temperature of the water will be checked before using the moist heat packs. 3. Responsibility (title(s) only): Response: Manager 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: Completed 5/8/13. Tag: S 1162 Finding(s): 4 - 7 1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction): Response: The Clinical Engineering Department will create a Quarterly Preventive Maintenance Calendar for the 2 Linear Accelerators located at the Radiation Oncology Center. A Planned Event notice to perform Quarterly Maintenance will be issued 30 days in advance to the Vendor and the Radiation Oncology Center Medical Physics Staff via Email and a phone call. The Vendor is to coordinate Quarterly Inspections with the Radiation Oncology Center Medical Physics Staff. The Vendor is to send PM reports to the Radiation Oncology Center Manager and the Hospital Clinical</p>	

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	<p>conducted on 3/25/2013, 11/19/12, and 8/15/12. The facility could not provide the last routine preventive maintenance inspection on Linear Accelerator IX2. Linear Accelerator IX2 was operational as of October 2009.</p> <p>6. At 10:15 AM on 5/8/2013, the Linear Accelerator technician indicated the manufacturer requires the equipment to have preventive maintenance every quarter and some items less often. The technician indicated when he/she services the 2 Linear Accelerators, the technician would perform preventive maintenance and it would be in his/her work orders.</p> <p>7. At 10:20 AM on 5/8/2013, staff member #44 indicated he/she does not have a preventive maintenance schedule on the 2 Linear Accelerators. The staff member confirmed the documentation he/she could provide evidence the Linear Accelerators are not having preventative maintenance</p>		<p>Engineering Department via email. The Radiation Oncology Center Staff will read, print out, take action on, and any deficiencies noted. The Clinical Engineering Department will close the Planned Event Work Order upon receiving a successfully completed Service Report from the Vendor. 2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?): Response: The Clinical Engineering Department will notify the Radiation Oncology Center Medical Physics Staff if Vendor Service Reports are not received in 10 working days. When Reports are received the Radiation Oncology Staff will file Reports in a 3 ring binder by quarter and year to be available for Regulatory review. 3. Responsibility (title(s) only): Response: Clinical Engineering and Medical Physics Staff 4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases): Response: Quarterly Planned Event scheduling to be completed by June 15, 2013.</p>	

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S001164	<p>inspections quarterly as required by the manufacturer. The staff member indicated the service work orders and documentation of the 2 Linear Accelerators are maintained at the off-site and not at the hospital's Clinical Engineering Department.</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, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and staff interview, the facility failed to assure preventive maintenance was conducted on 5 of 5 cribs located in Indiana University Health</p>	S001164	<p>Tag: S 1164 Finding(s): 1 - 3</p> <p>1. Plan of Correction (how are you going to correct the deficiency? If already corrected, include the steps taken and the</p>	05/30/2013

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	<p>Bloomington Hospital.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Environment of Care policy #6-110 (last reviewed 5/9/2012) states, "All inventory of Medical Equipment, along with history of each device included in the program is maintained in the Clinical Engineering Department: PM Procedures; Test frequencies; Management information; Who services the device; and Manufacturer and parts vendor information." The manufacturer's recommendation for preventative maintenance for the hospital baby cribs states, "The preventative maintenance program should be performed at least twice a year." At 1:05 PM on 5/7/2013, staff member #24 indicated the hospital has 5 baby cribs and 3 of them are currently in use. The staff member indicated the hospital does not 		<p>date of correction):</p> <p>Response:</p> <p>The 5 Cribs have been added to the Equipment Inventory. A semi-annual planned event inspection specific to cribs has been added to our computerized maintenance program. A check list with 25 items will be a part of the inspection process for Cribs.</p> <p>2. Prevention strategy (How are you going to prevent the deficiency from recurring in the future, i.e. monitoring, observation?):</p> <p>Response:</p> <p>When performing the annual review of the equipment risk based program make sure all Cribs have been PM'd according to schedule and that there are no outstanding deficiencies. .</p> <p>3. Responsibility (title(s) only):</p> <p>Response:</p> <p>Manager of Environment of Care & Plant Operations Supervisor</p> <p>4. Implementation Date (By what date are you going to have the deficiency corrected? Specific date within 30 days; if needs to be phased in, the plan must be written in incremental 30 day phases):</p>	

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	have preventative maintenance inspections on the baby cribs.		Response: The Cribs were added to the inventory May 30, 2013 and their inspection is scheduled for June 2013.		