

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151300	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/30/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL OF BREMEN INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 HIGH RD BREMEN, IN 46506		
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 10/29/2012 through 10/30/2012</p> <p>Facility Number: 005097</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 11/16/12</p>	S0000			

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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S0406	<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> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure three services (Radiology - Diagnostic, Bioengineering, and Maintenance) were part of its comprehensive quality assessment and improvement (QA&I) program and the facility failed to conduct quarterly meetings for the Quality and Safety Committee as defined in the hospital's Performance Improvement Plan.</p> <p>Findings included:</p> <p>1. Community Hospital of Bremen 2011 Performance Improvement</p>	S0406	<p>QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) All department directors are being included in the bi-monthly quality meetings and have been assigned the appropriate tasks for his/her department. The deficient area of Radiology-Diagnostic is developing forms to evaluate this area and developing quality improvement projects as deemed necessary. Bioengineering, and Maintenance are submitting their data to the quality committee. Bimonthly meetings will be held to review the progress of the individual departments as well as the hospital as a whole. Departmental quality data will be submitted electronically on an ongoing basis, with each department making a formal presentation to the committee at least annually. This data and</p>	11/30/2012	

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	<p>Plan implements all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. The Performance Improvement Plan article VI section D states, "The committees will meet at least quarterly..."</p> <p>2. The Quality Performance and Safety Committee meetings were reviewed for 2011 and 2012. The following services were not monitored by the committee: Radiology - Diagnostic, Bioengineering, and Maintenance.</p> <p>3. At 2:15 PM on 10/30/2012, staff member #1 confirmed that Bioengineering and Maintenance services were not being evaluated by the Quality Performance and Safety Committee.</p> <p>4. In 2012, the facility had 3 complete quarters. The facility only provided 1 meeting minutes for the Quality and Patient Safety Committee: January 30, 2012.</p>		findings will be summarized and presented to the quality committee of the Board of Directors. The Quality Director is responsible for coordinating our quality information to correct the above deficiency. Each department director is responsible for monitoring and evaluating the care and services provided within their department. The date of correction is November 30, 2012.				

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	5. At 2:25 PM on 10/30/2012, staff member #3 indicated the Quality and Patient Safety Committee only met once this year. The staff member confirmed the committee did not conduct a meeting for the second and third quarter of 2012.			

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, document review, and staff interview, the facility failed to ensure the Blood Bank's designated handwashing sink was free from obstruction and ensure blood vacutainers were not stored in the Material's Handling Department with a date that exceeds the expiration date.</p> <p>Findings included:</p> <p>1. At 1:05 PM on 10/29/2012, the Laboratory Department was toured. The Blood Bank Room located within the Laboratory was inspected. A porcelain designated hand washing sink was observed filled with ice and obstructed the use of the technician who was putting away the blood in the refrigerated unit.</p>	S0554	<p>Policy was established for lab related to designated handwashing sink Lab policy LAB-008 Sink Usage is established and effective 10-31-2012. All staff members have been in-serviced on this policy. The Lab director is responsible for the correction of the deficiency, and ongoing compliance. Materials Management- policy was developed and implemented 11-1-12.</p> <p>The Materials Management director of the hospital is responsible for the correction of this deficiency and ongoing compliance.</p>	10/31/2012	

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	<p>2. At 1:15 PM on 10/29/2012, staff member #7 indicated the ice was from the coolers the blood was packed in when it was delivered to the hospital's Blood Bank. The staff member confirmed the contaminated ice in the hand washing sink was an infection control concern.</p> <p>3. At 1:25 PM on 10/29/2012, the Material's Handling Department was toured. The shelving unit within the department that contained blood vacutainers was inspected. The shelf had 2 cases of 100-each of red cap blood vacutainers that were expired. The expiration on the cases were 8/2012.</p>			

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S0596	<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 control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and staff interview, the facility failed to properly disinfect physical therapy equipment according to the manufacturer's recommendations.</p> <p>Findings included:</p> <p>1. At 12:30 PM on 10/29/2012, staff member #10 indicated he/she uses Virex 256 disinfectant cleaner to disinfect the equipment in the Physical Therapy Department. The staff member indicated he/she uses a spray bottle and sprays the disinfectant all over the item. Then</p>	S0596	The physical and occupational therapy staff, including aides, were in-serviced on the infection control policy regarding cleaning and disinfecting patient care equipment in the therapy department. In addition to this in-service, this policy will be reviewed during the annual competency for each employee to ensure continued compliance. The Director of Therapy is responsible for the correction of this deficiency and ongoing monitoring for compliance.	11/01/2012			

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	<p>the staff member would retrieve a dry wiping cloth out of the linen cabinet and wipe the disinfectant cleaner right off. The staff member indicated he/she did not know what the contact time was for the disinfectant. The staff member confirmed the chemical was not left on the equipment the required 10 minutes as defined by the manufacturer.</p> <p>2. Johnson Wax Professional Virex 256 reference sheet indicates the chemical has a 10-minute contact time after it would be applied to the surface of the equipment.</p>			

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S0787	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(8)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(8) Diagnostic impression and condition on discharge documented by the practitioner, and disposition of the patient and time of dismissal.</p> <p>Based on medical record review and interview, the practitioner failed to document the condition on discharge for 10 of 12 patients (#N3, N4, N5, N6, N8, N10, N16, N18, N19, N20), the time of discharge for 4 of 12 patients (#N8, N10, N18, N19), and the diagnosis for 2 of 12 patients (#N3, N10) in the areas provided on the Emergency Department Patient Care Records.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The medical record for patient #N3 lacked documentation of the condition on disposition from the emergency department and the diagnosis on the Emergency Department Patient Care Record. 2. The medical record for patient #N4 lacked documentation of the condition on disposition from the emergency department on the Emergency Department Patient Care Record. 3. The medical record for patient #N5 lacked documentation of the condition on disposition from the emergency department on the Emergency Department Patient Care Record. 4. The medical record for patient #N6 lacked documentation of the condition on disposition 	S0787	<p>An Emergency Department Physician Chart audit form has been developed and then instituted on November 6, 2012. Three of the standards on the form include: Disposition/condition marked on discharge, diagnosis documented, and time patient seen. Records are flagged for deficiency and given to the responsible physician for completion. Incomplete records are brought to the physicians attention, they have 30 days to complete deficiencies, after 30 days a notice of deficiency and Notice of Suspension of priviledges until record completed is issued. A quarterly report of the findings will be reviewed at the ED committee meeting. These meeting minutes flow to the Medical Staff committee, our Professional and quality sub committee of the Board of Directors and then to the full Board. The Health Information Services Diretor is responsible for the correction of the above</p>	11/06/2012	

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	<p>from the emergency department on the Emergency Department Patient Care Record.</p> <p>5. The medical record for patient #N8 lacked documentation of the condition on disposition from the emergency department and the time on the Emergency Department Patient Care Record.</p> <p>6. The medical record for patient #N10 lacked documentation of the condition on disposition from the emergency department, the diagnosis, and the time on the Emergency Department Patient Care Record.</p> <p>7. The medical record for patient #N16 lacked documentation of the condition on disposition from the emergency department on the Emergency Department Patient Care Record.</p> <p>8. The medical record for patient #N18 lacked documentation of the condition on disposition from the emergency department and the time on the Emergency Department Patient Care Record.</p> <p>9. The medical record for patient #N19 lacked documentation of the condition on disposition from the emergency department and the time on the Emergency Department Patient Care Record.</p> <p>10. The medical record for patient #N20 lacked documentation of the condition on disposition from the emergency department on the Emergency Department Patient Care Record.</p> <p>11. At 3:00 PM on 10/30/12, staff member #A4, who navigated the Electronic Medical Record (EMR), confirmed the lack of complete documentation on the Emergency Department Patient Care Records.</p>		<p>deficiency, ongoing collection of the audit information and submission to the ED committee.</p> <p>.</p>		

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S0870	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure verbal/telephone orders were authenticated by the physician according to policy for 11 of 20 closed medical records reviewed (#N1, N3, N4, N5, N7, N8, N11, N16, N17, N18, N19).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Authentication of Record Entries", last approved 03/21/12, indicated, "...7. All entries, written or transcribed, in the medical record must be timed, dated and authenticated. Timing documents the time and date of each entry (orders, reports, notes, etc.)." The facility policy "Verbal Orders, Authentication of", last revised 8/12, from the Medical Surgical Department, indicated, "...Verbal orders must be signed by the physician within 48 hours." Another facility policy "Verbal Orders", last 	S0870	The medical staff was informed at the medical staff meeting on November 9, 2012 of the survey results and were instructed that all entries including verbal and telephone orders must be signed, dated and timed. The health information services department is reviewing patient records for physician signature, date and time on all verbal and telephone orders. Records will be flagged and returned to the physician for completion. Incomplete records are brought to the physicians attention, they have 30 days to complete deficiencies, after 30 days a notice of deficiency and Notice of Suspension of privileges until record completed is issued. There is now one hospital policy for verbal orders which is the Health Information Services Department Policy	11/20/2012			

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	<p>approved 03/21/12, from the Health Information Services Department, indicated, "...Verbal orders must be signed, dated and timed within forty-eight (48) hours unless a read back and verify process is used in which case a signature should be obtained within thirty (30) days of the patient's discharge."</p> <p>4. The medical record for patient #N1 indicated a telephone order from 08/30/12 and another from 08/31/12, both using the read back and verify process, with physician signatures that were not dated or timed.</p> <p>5. The medical record for patient #N3 indicated two telephone orders from 07/22/12, using the read back and verify process, with physician signatures that were not dated or timed.</p> <p>6. The medical record for patient #N4 indicated two telephone orders from 07/23/12 using the read back and verify process. The first order was signed by the physician at 0750 on 08/07/12 and the second order was signed, but not dated or timed.</p> <p>7. The medical record for patient #N5 indicated a telephone order from 08/03/12, using the read back and verify process, with a physician signature that was not dated or timed.</p> <p>8. The medical record for patient #N7 indicated a telephone order from 08/07/12, using the read back and verify process, that was signed by the physician at 0752 on 08/24/12.</p> <p>9. The medical record for patient #N8 indicated a verbal order from 09/18/12, using the read back and verify process, with a physician signature that was not dated or timed.</p> <p>10. The medical record for patient #N11 indicated</p>		#HIS003 which states that "Verbal orders must be signed, dated and timed within forty-eight (48) hours unless a read back and verify process is used, in which case a signature and date should be obtained within thirty (30) days of the patient's discharge."The Health Information Services Director is the responsible person for the correction of this deficiency.		

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	<p>a telephone order from 06/07/12, using the read back and verify process, with a physician signature that was not dated or timed.</p> <p>11. The medical record for patient #N16 indicated a telephone order from 06/03/12, using the read back and verify process, that was signed by the physician at 0900 on 06/09/12.</p> <p>12. The medical record for patient #N17 indicated a telephone order from 05/13/12, using the read back and verify process, that was signed by the physician at 0730 on 05/22/12. Another telephone order was documented on 05/15/12 and signed by the physician at 1820 on 05/24/12.</p> <p>13. The medical record for patient #N18 indicated a telephone order from 04/04/12, using the read back and verify process, with a physician signature that was not dated or timed.</p> <p>14. The medical record for patient #N19 indicated a telephone order from 07/26/12, using the read back and verify process, that was signed by the physician at 0800 on 08/03/12.</p> <p>15. At 10:00 AM on 10/30/12, staff member #A4 indicated he/she thought verbal and telephone orders needed to signed by the physician within 48 hours and confirmed the medical record findings.</p> <p>16. At 2:00 PM on 10/30/12, staff members #A2, A3, and A16 acknowledged the discrepancies with the policies, but indicated the physicians had 30 days to sign any telephone or verbal orders.</p>			

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S0952	<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 review, medical record review, and interview, the facility failed to ensure staff followed their policy for blood administration in 3 of 4 records reviewed of inpatients who received blood transfusions (#N2, N4, and N5).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Blood and Blood Component Administration", last revised 7/12, indicated, "...12. At a minimum. Vital Signs should be recorded before the transfusion begins, 15 minutes after the transfusion begins, and every half hour until the transfusion is complete. The majority of transfusion reactions occur within approximately 15- 45 minutes from the start of the infusion. All vital signs must be documented on Blood Component Form and Blood Product Flow Sheet." The medical record for patient #N2 indicated a unit of blood was started at 1435 on 07/08/12 and completed at 1725. The Blood Component Form and Blood Product Flow Sheet indicated vital signs taken at 1435, 1450, 1505, 1556, 1700, 1725, and 1730, not every half hour as specified in the policy. 	S0952	<p>Policy and Procedures for Blood Transfusions were reviewed and modified to be consistent with American Association of Blood Banks. Staff in-serviced on new policy and procedure. A form was developed and implemented. Chart audits will be completed using this form to maintain compliance. Director of Medical/Surgical responsible for education, training, and staff competency on blood administration documentaion. The Director of Laboratory is responsible for implementing and monitoring the American Association of Blood Banks standard.</p>	10/31/2012			

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	<p>3. The medical record for patient #N4 indicated a unit of blood was started at 1330 on 07/20/12 and completed at 1645. The Blood Component Form and Blood Product Flow Sheet indicated vital signs taken at 1328, 1345, 1400, 1413, 1430, 1503, then not again until 1645 at the completion of the unit.</p> <p>4. The medical record for patient #N5 indicated 2 units of blood were infused on 08/02/12. The first unit was started at 0915 and vital signs were documented at 0910, 0930, 0945, 1000, 1030, 1100, 1130, then not again until 1300 at the completion of the unit. The second unit was started at 1303 and vital signs were documented at 1300, 1318, 1345, 1400, 1430, then not again until 1605 at the completion of the unit.</p> <p>5. At 2:00 PM on 10/30/12, staff member #A4, who navigated the Electronic Medical Record (EMR), confirmed the missing vital signs on the blood transfusion records.</p>				

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S1118	<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>Based on observation, manufacturer's directions 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 two (2) instances, Maintenance Department and Main Electrical Room and failed to ensure the safety of the staff when handling chemicals and contaminated equipment in 2 areas (decontamination room and scope cleaning room).</p> <p>Findings included:</p> <p>1. At 12:05 PM on 10/29/2012, the</p>	S1118	<p>On 11/5/12 the grinding wheel and safety guards were corrected. The unit will be subject to regular inspections per manufacturer specifications. The inspection schedule will go into effect 12/5/12. On 11/5/12 the articles in the electrical room were all removed. The area will be subject to regular inspections. The inspection schedule will go into effect 12/5/12. On 11/27/12 a quote for installation of eye wash stations in the identified areas were obtained. The units are planned to be installed and operational by 1/1/13. The Director of Plant Operations is responsible for the correction of this deficiency and the ongoing monitoring, inspections and preventive maintenance.</p>	01/01/2013			

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	<p>Maintenance Department was inspected. The room had a yellow grinding/abrasive bench mounted wheels in the room. The right wheel of the bench mounted grinding wheel surface condition had caked on white foreign matter that can repel toward someone when it is used. The bench mounted abrasive/grinding wheels both safety guards were angled upward not in the proper position to prevent sparks or foreign objects to repel backwards toward the operator.</p> <p>2. At 12:15 PM on 10/29/2012, the main electrical room was toured. In middle of the room, there were high voltage electrical panels back-to-back with and opening aisle of 2-feet between the backs of the electrical panels. The opening between the high voltage electrical panels were filled with assorted boxes of electrical supplies, rolled-up architectural plans, and other items that could cause a safety hazard having combustible</p>			
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	<p>items in contact with high voltage electrical boxes.</p> <p>3. At 12:20 PM on 10/29/2012, staff member #8 indicated the assorted boxes, hardware, etc were from the construction company. The staff member confirmed the boxes and other supplies stored in contact with the electrical panels is not a safe practice and it also clutters the electrical room in a whole.</p> <p>4. During the tour of the decontamination room at 3:15 PM on 10/29/12, accompanied by staff members #A4 and A15, two chemicals were observed for use by staff for contaminated equipment and supplies. The manufacturer's directions on both chemicals, Prolystica Enzymatic Cleaner and Electronic Spray Cleaner, indicated a continuous 15 minute flush was the first aid for any splashes in the eyes. The room had a wall mounted station containing two 16-ounce bottles of irrigation solution, each providing approximately 2-3 minutes of flushing. The room lacked an actual eye wash station capable of providing the necessary 15 minute flushing if needed.</p> <p>5. During the tour of the scope cleaning</p>						

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	<p>room at 3:45 PM on 10/29/12, accompanied by staff members #A4 and A15, a chemical was observed for use by staff for contaminated equipment and supplies. The manufacturer's directions on the chemical, Prolystica Enzymatic Cleaner, indicated a continuous 15 minute flush was the first aid for any splashes in the eyes. The room had a wall mounted station containing two 16-ounce bottles of irrigation solution, each providing approximately 2-3 minutes of flushing. The room lacked an actual eye wash station capable of providing the necessary 15 minute flushing if needed.</p> <p>6. At 3:50 PM on 10/29/12, staff member #A15 indicated the only eye wash station was in the lab which was not in close proximity to either of the surgical cleaning areas.</p>			

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S1146	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(8)(A)(B)(C)</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>(8) Prior to the start of construction, addition, or renovation projects, detailed architectural and operational plans for construction shall be submitted to the plan review division of the department of fire and building services and to the division of sanitary engineering of the department, as follows:</p> <p>(A) Working drawings, project manual, and specifications shall be included. (B) Prior to submission of final plans and specifications, recognized standards and codes, including infection control standards, shall be reviewed as required in section 2(f)(2) of this rule. (C) All required approvals shall be obtained from the state building commissioner and final approval from division of sanitary engineering of the department prior to issuance of the occupancy letter by the division.</p> <p>Based on document review, observation, and staff interview, the facility failed to submit detailed architectural and operational plans</p>	S1146	The MRI suite addition construction plans were submitted to the Indiana State Department of Health, Department of Health Care Engineering on November 25,	01/01/2013

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	<p>for renovation to the division of sanitary engineering of the Indiana State Department of Health.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 2:00 PM on 10/29/2012, the physical plant was toured. The facility was observed with a Mobil MRI. The facility was adding on a new addition to the hospital. The new 720 sq/ft addition was for the hospital's MRI Suite. Operating plans were submitted to the Department of Homeland Security and Indiana Building and Fire Services for an additional 720 square feet to the existing hospital for a MRI suite. The date of start of construction was identified on the applications was September 2012. The facility was unable to provide an approval letter from the Indiana State Department of Health Sanitary Engineering Department. At 1:30 PM on 10/30/2012, staff member #8 indicated he/she does 		<p>2012. The plans were submitted by John Werntz, Project Architect, as per the requirements of the Health Care Engineering Department. The project plans, including blueprints, specifications, equipment details, equipment layout and facility layout were submitted in their entirety. The plans were reviewed against and submitted with references to the AIA guidelines for Imaging Suites (7.10) and Magnetic Resonance Imaging (7.10.E). In addition, the project architect has been in communication with Todd Hite, Program Director, to ensure that the plans have been received by ISDH. Linda Barrett, V.P. of Clinical Services, is responsible for communications with the project architect to ensure that a final approval letter is obtained from the Indiana State Department of Health prior to the operation of the MRI suite. Any issues that arise upon the review by the Health Care Engineering Department will be addressed immediately and submitted for review and approval. The hospital construction project checklist has been updated to include that copies of all required permits must be obtained prior to initiation of any project, including not only state, county and local building permits, but also ISDH sanitary engineering department permits. The Director of Plant Operations is responsible for</p>		

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	<p>not have an approval letter from the Indiana State Department of Health. The staff member indicated he/she contacted the architect firm; the firm indicated they did not know architect plans should be submitted to the sanitary engineering department of the Indiana State Department of Health. The staff member indicated the new addition to the hospital has been under construction without approval from the Indiana Department of Health sanitary engineering department.</p> <p>4. At 2:15 PM on 10/30/2012, staff member #1 indicated he/she thought the operational plans of the new MRI suite were submitted to Indiana State Department of Health for approval. However, he/she was surprised when discovering the plans had not been sent to the health department as required. The staff member confirmed the plans should have been submitted to the health department.</p>		ensuring that copies of all permits are on-site prior to the start of any project. A project compliance monitoring for all permits will be completed prior to project start.		

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