

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/15/2014
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 W 16TH ST BEDFORD, IN 47421
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 004683</p> <p>Survey Dates: 10/14/14 to 10/15/14</p> <p>Surveyors: Trisha Goodwin. RN BS Public Health Nurse Surveyor</p> <p>Ken Ziegler Medical Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 11/06/14</p>	S000000		
S000406	<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>			

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) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include four (4) services in the quality assessment and improvement program (QAPI).</p> <p>Findings:</p> <p>1. Review of facility QAPI meeting minutes dated 1/2/14, 3/21/14, 4/3/14, 6/5/14, 7/3/14 &amp; 8/7/14 lacked evidence of quality monitors or standards for four (4) services as follows: post-operative recovery, psychiatric emergency telemedicine, teleradiology, and orthopedic surgery.</p> <p>2. In interview on 10/15/14 at 2:15pm A7, Director of Quality Compliance, confirmed the above services had not been included in the QAPI activity.</p>	S000406	<p><b>Plan of Correction:</b> 1. Hospital Document Request QA/PI Monitors document provided by ISDH Surveyor reviewed for applicable services.</p> <p><b>Responsible Person:</b> Director of Quality, Compliance, and Risk –Kathy Lewis, RN, MS, DHSc <b>Completion date:</b> 10-15-2014</p> <p>2. Review Facility Quality Plan <b>Responsible Person:</b> Director of Quality, Compliance, and Risk –Kathy Lewis, RN, MS, DHSc <b>Completion date:</b> 10-15-2014</p> <p>3. Add the following services to the facility Monthly Quality Monitoring Report: Post-op recovery, psychiatric emergency telemedicine, stroke telemedicine, tele-radiology, eye surgery, and orthopedic surgery. <b>Responsible Person:</b> Director of Quality, Compliance, and Risk –Kathy Lewis, RN, MS, DHSc <b>Completion date:</b> 11-19-2014</p> <p>4. QA/PI studies will be sent to the Quality Department Monthly for inclusion in the Monthly Quality Monitoring Report . <b>Responsible Persons:</b> <b>Diagnostic Imaging Director-</b> Scott Wagner: Tele-radiology <b>Surgery Director –</b> Cathy Blackwell, RN: Post-op Recovery, Eye Surgeries, and Orthopedic Surgeries <b>Emergency Director –</b> Connie Kinder, RN: Psychiatric</p>	11/01/2014			

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S000408	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</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>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).</p> <p>Based on document review and interview, the hospital failed to include all functions of the facility in the quality assurance and performance improvement program (QAPI) in one (1) instance.</p> <p>Findings:</p> <p>1. Review of facility QAPI meeting minutes dated 1/2/14, 3/21/14, 4/3/14,</p>	S000408	<p>Emergency Telemedicine and Stroke Telemedicine <b>Completion date: Data to Quality monthly beginning with November 1, 2014 Data</b></p> <p><b>Plan of Correction:</b> 1. Hospital Document Request QA/PI Monitors document provided by ISDH Surveyor reviewed for applicable services. <b>Responsible Person:</b> Director of Quality, Compliance, and Risk –Kathy Lewis, RN, MS, DHSc <b>Completion date: 10-15-2014</b> 2. Review Facility Quality Plan <b>Responsible Person:</b></p>	11/01/2014

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S001162	<p>6/5/14, 7/3/14 &amp; 8/7/14 lacked evidence of quality monitoring for the function of discharge planning.</p> <p>2. In interview on 10/15/14 at 2:15pm A7, Director of Quality Compliance, confirmed the above function had not been included in the QAPI activity and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(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:  (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.  Based on document review and interview, the hospital failed to assure an</p>	S001162	<p>Director of Quality, Compliance, and Risk –Kathy Lewis, RN, MS, DHSc <b>Completion date: 10-15-2014</b></p> <p>3. Add the following services to the facility Monthly Quality Monitoring Report: Discharge Planning. <b>Responsible Person:</b> Director of Quality, Compliance, and Risk –Kathy Lewis, RN, MS, DHSc <b>Completion date: 11-19-2014</b></p> <p>4. QA/PI studies will be sent to the Quality Department Monthly for inclusion in the Monthly Quality Monitoring Report . <b>Responsible Persons: Teresa Mathis, RN:</b> Discharge Planning <b>Completion date: Data to Quality monthly beginning with November 1, 2014 Data</b></p> <p><b>Plan of Correction:</b> 1. Citation S1162 reviewed concerning the lack of PM on</p>	12/05/2014	

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	<p>appropriate maintenance schedule for the emergency code system in any instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of preventive maintenance (PM) documents lacked evidence of PM for the emergency call (code) system.</li> <li>2. In interview on 10/15/14 at 2:15pm A7, Director of Quality Compliance, indicated the overhead PA to be the equipment utilized by the facility for emergency notifications. A7 further indicated the facility did not have evidence of PM performed on that system and no further documentation was provided prior to exit.</li> </ol>		<p>Overhead Emergency Call System <b>Responsible Person:</b> Director of Quality, Compliance, and Risk – Kathy Lewis, RN, MS, DHSc Director of Plant Operations – Chad Shock <b>Completion date: 10-15-2014</b></p> <p>2. Overhead Emergency Call System installer scheduled to come to the facility to check System operations. <b>Responsible Person:</b> Director of Plant Operations – Chad Shock Plant Operations Administrative Assistant – Jolene Rayhill <b>Completion date: October 21, 2014</b></p> <p>3. Overhead Emergency Call System installer to facility to check system operations <b>Responsible Person:</b> Director of Plant Operations – Chad Shock <b>Completion date: October 23, 2014</b></p> <p>4. Overhead Emergency Call System installer PM recommendations presented at the Environment of Care November 10th meeting <b>Responsible Person:</b> Director of Quality, Compliance, and Risk – Kathy Lewis, RN, MS, DHSc Director of Plant Operations – Chad Shock <b>Completion date: 11-10-2014</b></p> <p>5. Inventory and labeling of all Overhead Emergency Call System Speakers to be accomplished by Plant Operations then a semi-annual PM check of the Overhead Emergency Call System will begin.</p>		

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S001164	<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. Based on observation, document review and interview, the hospital failed to maintain preventive maintenance (PM) on all equipment in three (3) instances.</p> <p>Findings:</p> <p>1. During facility tour on 10/15/14 between 9:30am and 12:00pm, in the</p>	S001164	<p><b>Responsible Person:</b> Director of Plant Operations – Chad Shock <b>Completion date: To be completed by December 5, 2014</b></p> <p>6. The initial Overhead Emergency Call System PM will be sent to Quality. Semi- Annual PM Monitoring will be found in the facility PM monitoring log. <b>Responsible Person:</b> Director of Plant Operations – Chad Shock <b>Completion date: The initial PM data to be sent to Quality by December 5, 2014</b></p> <p><b>Plan of Correction:</b> 1. Citation S1164 reviewed concerning the lack of PM of Cardiac Rehab equipment: Cardiac 12 monitor, Tanita Scale, and a Schwinn stationary bike. <b>Responsible Person:</b> Director of Quality, Compliance, and Risk – Kathy Lewis, RN, MS, DHSc Director of Plant Operations –</p>	10/23/2014

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S001172	<p>presence of A7 &amp; A11, in the cardiac rehabilitation area the following three (3) pieces of equipment were observed without preventive maintenance stickers: Cardiac 12 monitor, Tanita scale and Schwinn stationary bike. Evidence of PM was requested of A7 at that time.</p> <p>2. Review of PM documents presented by A10, Administrative Coordinator of Biomed, lacked evidence of PM of the three (3) pieces of equipment listed above.</p> <p>3. In interview on 10/15/14 at 2:45pm A7, Director of Quality Compliance, confirmed the facility did not have evidence of PM on the above listed equipment and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p>		<p>Chad Shock Director of Cardiac Rehab and ICU – Jody Hill, RN, MSN <b>Completion date: 10-15-2014</b></p> <p>2. Plant Operations contacted Bio-Med to inventory and check the Cardiac 12 Monitor, Tanita Scale, and the Schwinn stationary bike <b>Responsible Person:</b> Director of Plant Operations – Chad Shock Plant Operations Administrative Assistant – Jolene Rayhill Director of Cardiac Rehab and ICU – Jody Hill, RN, MSN <b>Completion date: October 21,2014</b></p> <p>3. Bio-med inventoried and PM the Cardiac 12 Monitor, Tanita Scale, and the Schwinn stationary bike <b>Responsible Person:</b> Director of Plant Operations – Chad Shock Director of Cardiac Rehab and ICU – Jody Hill, RN, MSN <b>Completion date: October 23, 2014</b></p> <p>4. Scheduled PM Monitoring will be found in the facility PM monitoring log. <b>Responsible Person:</b> Director of Plant Operations – Chad Shock <b>Completion date: October 23, 2014</b></p>				

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	<p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, the hospital failed to maintain a clean and orderly building environment in two (2) instances.</p> <p>Findings:</p> <p>1. During facility tour on 10/15/14 between 9:30am and 12:15pm, in the presence of A7 &amp; A11, in air handler room 1 and air handler room 2, a high amount of clutter was observed atop the handlers and on the floor. Patient care equipment was also noted to be stored in this area. Adult beds, pediatric cribs, &amp; mattresses were being stored uncovered and were notably covered with dust and ceiling debris. In air handler room 2, it was noted that linens in bags were also being stored. One bag containing yellow blankets was opened and exposed to the dust and debris of the room.</p>	S001172	<p><b>Plan of Correction:</b></p> <p>1. Citation S1172 reviewed concerning the condition of two of the facility air handler</p> <p>Rooms (Rooms 1 &amp; 2).</p> <p><b>Responsible Person:</b></p> <p>Director of Quality, Compliance, and Risk – Kathy Lewis, RN, MS, DHSc</p> <p>Director of Plant Operations – Chad Shock</p> <p><b>Completion date: 10-15-2014</b></p> <p>2. Air handler rooms cleaned using Lean Methodology 6S (Sort, Set Order, Safety,</p>	11/01/2014	

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			<p>Shine, Standardize, and Sustain)</p> <p><b>Responsible Person:</b></p> <p>Director of Quality, Compliance, and Risk – Kathy Lewis, RN, MS, DHSc</p> <p>Coordinator for Quality/Transformation – Kelly Arthur</p> <p>Director of Plant Operations – Chad Shock</p> <p><b>Completion date: 11-5-2014</b></p> <p>3. Monitoring of compliance with 6 S of the (2) Air Handler rooms will be sent to the</p> <p>Quality Director Monthly.</p> <p><b>Responsible Person:</b></p> <p>Director of Plant Operations – Chad Shock</p> <p>Coordinator for Quality/Transformation – Kelly Arthur</p>	

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