

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005079</p> <p>Survey Date: 02-20-12 to 02-22-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Albert Daeger, SFPIO, CFM Medical Surveyor 3</p> <p>QA: claughlin 03/05/12</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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S0178	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based upon observation and interview, the facility failed to post a license copy in a common public area for each hospital services off-site location for 2 off-sites.</p> <p>Findings:</p> <p>1. Lack of a posted license was observed in the common public areas of the following outpatient services: a) on 2-21-12 at 0830 hours, during a facility tour of the outpatient wound center. b) on 2-21-12 at 0910 hours, during a tour of the outpatient pediatric rehabilitation.</p> <p>2. During an interview on 2-21-12 at 0830 hours, staff A8 confirmed the location lacked a posted license.</p>	S0178	<p>On February 23, 2012, the Director of Plant Operations confirmed the hospital license had been posted at the off-site locations -Attachment #1 (Exhibit M1) The Director of Plant Operations will be meeting monthly with Vice President and General Counsel and the Property Manager, to review all off-site locations to determine which locations have been added or deleted from the hospital license. The Director of Plant Operations is responsible for posting hospital license at all off-site locations under the hospital license.</p>	02/23/2012

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	3. During an interview on 2-21-12 at 0910 hours, staff A8 confirmed the location lacked a posted license.				

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S0308	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review and interview, the facility failed to ensure that orientation to applicable hospital and department policy/procedures was provided to contracted housekeeping personnel for 6 off-site locations.</p> <p>Findings:</p> <p>1. On 2-20-12 at 1100 hours, staff A3 was requested to provide a policy/procedure and documentation of orientation for housekeeping staff providing services at off-site locations and none was provided prior to exit.</p> <p>2. Review of the Cleaning Services</p>	S0308	The infection control department, human resources department, environmental services department, and the maintenance department met to determine a comprehensive orientation program for the contracted housekeeping services. The orientation will take place on Thursday, March 29, at 9:00 am, for all employees of the contracted services. (Attachement #2)The orientation will be conducted by hospital staff from the appropriate departments. After the initial orientation, the Property Manager will be responsible for conducting the orientation for all new contracted employees prior to their start date. The Director of Plant Operations will be responsible for maintaining the documenting of those participating in the orientation	03/29/2012	

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	<p>Agreement for the Pediatric Rehabilitation Center and Wound Healing Center off-sites indicated the following: "VENDOR shall complete such orientation and training as requested by COMPANY. "</p> <p>3. During an interview on 2-22-12 at 1000 hours, staff A21 indicated that the contracted housekeeping staff received orientation and training provided by the hospital.</p> <p>4. During an interview on 2-22-12 at 1415 hours, staff A21 confirmed that the hospital lacked documentation of orientation for contracted housekeeping staff at 6 off-site locations.</p>		program.				

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S0332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on document review and interview, the hospital failed to document housekeeping personnel competency for cleaning and disinfecting its operating rooms and failed to document contracted housekeeping personnel competency for cleaning and disinfecting at 6 off-site locations.</p> <p>Findings:</p> <p>1. On 2-20-12 at 1100 hours, staff A3 was requested to provide policies/procedures and documentation of competency for its operating room housekeeping personnel and off-site contracted services housekeeping staff and no documentation was received for contracted services housekeeping staff prior to exit.</p>	S0332	<p>3/5/12 - The Basic Competency Checklist for Environmental Services Service Assistant was updated to include an area to document training for terminal OR cleaning. (Attachment #3) It is the responsibility of the training Manager/Supervisor to ensure that education is given and documented for OR cleaning. The Basic Competency Inventory Checklist for Contract Cleaning Vendor Services has been developed and will be completed for each contracted staff member providing services at off-site locations at the completion of the 3/29/12 training session.</p>	03/29/2012			

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	<p>2. The policy/procedure Competency (approved 5-11) indicated the following: "Each department shall maintain a set of competencies for each job assigned within that department."</p> <p>3. The document Environmental/Linen Services Basic Competency Inventory Checklist (revised 2-1-2011) lacked a provision for ensuring staff competency for housekeeping services in the operating room (OR) environment.</p> <p>4. During an interview on 2-21-12 at 1005 hours, staff A7 confirmed that the housekeeping competency checklist lacked an OR provision.</p> <p>5. On 2-22-12 at 0900 hours, staff A21 was requested to provide documentation of competency for contracted housekeeping staff providing services at off-site locations and none was provided prior to exit.</p> <p>6. During an interview on 2-22-12 at 1415 hours, staff A21 confirmed that the hospital lacked documentation of competency for 4 contracted services providing housekeeping staff at off-site locations.</p>						

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S0392	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(2)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(2) That the services performed under a contract are provided in a safe and effective manner and are included in the hospital's quality assessment and improvement program.</p> <p>Based on document review and interview, the governing board failed to ensure that services provided by agreement were provided in a safe and effective manner for its off-site contracted housekeeping services at 6 locations.</p> <p>Findings:</p> <p>1. The policy/procedure Contract Administration Policy (revised 11-11) failed to ensure that each service was evaluated by the contract Administrator using criteria specified in its contractual agreement and failed to indicate a process (direct observation, outcome indicators, process indicators) to validate that housekeeping services were provided in a safe and effective manner using hospital-approved products and procedures.</p>	S0392	<p>1. Review of hospital contracted services are to be coordinated with and in accordance with the Hospital Quality/Safety Improvement Plan (QSM-002-P), which has been revised to specifically include contracted services (see attachment # 5). The Administrator Contract Services Evaluation Form (ADM-LD-110-a-F) has been revised (see attachment #6) whereby the Administrator responsible for the applicable hospital service contract shall specify criteria and a process (i.e. direct observation, audit, chart review, process indicators, outcome indicators) upon which the Administrator will evaluate the services provided by collecting and reporting data concerning the hospital contracted services to Quality Management for reporting to the Quality/Safety Council and inclusion in the Hospital</p>	03/06/2012			

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	<p>2. On 2-22-12 at 0900 hours, staff A3 and A21 was requested to provide documentation identifying the off-site contracted housekeeping providers for the sleep lab, family practice clinic, and New Castle Ball Cancer Center and no documentation was provided prior to exit.</p> <p>3. Review of the Cleaning Services Agreements for the Pediatric Rehabilitation Center and Wound Healing Center off-sites indicated the following: "VENDOR shall complete such orientation and training as requested by COMPANY." On 2-22-12 at 0900 hours, staff A3 and A21 was requested to provide documentation of orientation and training provided or prepared by hospital personnel for off-site housekeeping providers at 6 locations and none was provided prior to exit.</p> <p>4. The Cleaning Services Agreements failed to require the use of hospital-approved disinfectants by each service and failed to indicate a list of cleaning products approved for use at each off-site if not supplied by the hospital. On 2-22-12 at 0900 hours, staff A3 and A21 was requested to provide documentation of cleaning products</p>		<p>Quality/Safety Improvement Plan, which will ensure and validate that contracted services are provided in a safe and effective manner and in compliance with all applicable laws and that any remedial actions are taken to improve services, if recommended by the Quality Council. The Contract Administration Policy (ADM-LD-110-P) has also been revised accordingly (see attachment #7).2. The Cleaning Services Agreements were hand delivered to the surveyor during interviews with staff, including sleep lab. The family practice clinic is serviced by hospital staff, and it is not a contracted service. The New Castle Ball Cancer Center is serviced by the landlord, Henry County Memorial Hospital, per the Lease Agreement. 3. Beginning in March, the Property Manager will be completing monthly audits on the services provided by the contracted housekeeping services at the off-site locations (See Attachment #8 & 9). The audits will be completed at the same time as the Environment of Care rounding audits. A summary of the audits will be presented quarterly to the Director of Plant Operations. The Director of Plant Operations will present the results of the audits to the Infection Control Committee on a quarterly 4. The Cleaning Services Agreement, Section II. A. provides that "VENDOR shall</p>				

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	<p>currently used by contracted housekeeping personnel at 6 off-site locations and none was provided prior to exit.</p> <p>5. During an interview on 2-22-12 at 1415 hours, staff A21 confirmed that the hospital lacked documentation of cleaning personnel orientation, training, competency, and cleaning products currently used by the contracted housekeeping providers at the off-site locations.</p>		<p>perform the Services in the highest-quality and professional manner and in accordance with all applicable laws, rules, regulations, COMPANY's policies and standards of any accrediting body of COMPANY."; thus, the housekeeping vendor is contractually required to utilize hospital-approved cleaning products, and Infection Control and Facilities Management have confirmed same. A list of the companies providing contracted housekeeping services to all the off-site locations is provided (Attachment #10 - Exhibit M2). For the orientation of the contracted housekeeping services reference the Plan of Correction for Deficiency S308.</p> <p>5. The Infection Control Committee will be responsible for approving the disinfectants used by all the contracted housekeeping services prior to their initial use. The Infection Control Committee is also responsible for approving any changes in the disinfectants used by all the contracted housekeeping services prior to the change. The Infection Control Committee will be responsible for notifying the contracted housekeeping services of the approval or denial of any disinfectants. Disinfectants currently used by all contracted services were reviewed and approved at the March 6, 2012 Infection Control Meeting. (See</p>		

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			Attachment #11)	

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S0394	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(3)</p> <p>(f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following:</p> <p>(3) That the hospital maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, the facility failed to maintain a list, including the scope and nature of services provided, of all contracted services for the hospital.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a list of 903 contracted service agreements provided by staff A3 on 2-20-12 failed to indicate a service provider for emergency generators and 2 off-site housekeeping services. 2. Facility documentation confirmed that a listed vendor (page 1, line 8) agreement expired 12-31-2011. 3. The list of contract service agreements (page 14, line 9) and (page 20, line 2) 	S0394	<p>The governing board is responsible for insuring the hospital maintains a list of all contracted services including the scope of nature of services provided. The service contract for the emergency generators has been provided (Attachment # 12 - Exhibit M3). The service contract for all the contracted housekeeping services has been provided (Attachment #13,14,15,16 - Exhibit M4). A list of the contracted housekeeping services for all off-site locations has been provided (Attachment #10 - Exhibit M2). The contracted service for the fire extinguisher at all off-site is being done by Canopy Management of a monthly basis as part of their property management agreement. Canopy is setting up the annual fire extinguisher service through Koorsen Protection. The Director of Plant Operations will be responsible for maintaining the documentation</p>	03/01/2012

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	<p>scope of services failed to indicate that the vendors provided housekeeping services for off-site locations operating under the hospital license and failed to indicate each vendor point of service.</p> <p>4. The list of contract service agreements scope of services: (pp 11, line 2) failed to indicate that the vendor provided fire extinguisher service. (pp 13, line 4) failed to indicate that the vendor provided radiological equipment calibration and certification. (pp 16, line 23) failed to indicate that the vendor provided medical waste disposal service.</p> <p>5. On 2-22-12 at 1415 hours, staff A21 confirmed that the list of contracted services had not been maintained and failed to indicate the scope of services provided for all providers.</p>		for all the fire extinguisher inspections. Stericycle is providing all the medical waste disposal services at the off-site locations.				

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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 interview, the facility failed to ensure that its contracted services were monitored through its Quality Assessment and Improvement (QA&I) program.</p> <p>Findings:</p> <p>1. The Quality/Patient Safety Plan (approved 6-11) lacked a provision for monitoring contracted services.</p> <p>2. During an interview on 02-20-12 at 1515 hours, staff A3 indicated that the legal department was responsible for the contract services management and evaluation for the facility. Staff A3</p>	S0406	<p>1. The Hospital Quality/Safety Improvement Plan (QSM-002-P) has been revised to specifically include contracted services (Attachment #5).</p> <p>2. Prior to the survey, Administrators recently completed their annual review of contracts, which was reported through the Quality Council on December 7, 2011, and annual contract report to the Hospital governing board on January 25, 2012. This annual review will continue. Additionally, prior to finalizing a hospital service contract, Quality Management will review and approve the intended contract and contracted services, which step has been added to the contract initiation process (see revised Internal Contract Summary (ADM-LD-110-b-F) (Attachment # 17) and revised Contract Administration Policy</p>	03/07/2012			

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	<p>indicated that the legal department determined the contracted service performance indicators without consulting the Quality/Safety Committee.</p> <p>3. The policy/procedure Contract Administration Policy (approved 11-11) indicated the following: " Active contracts are to be evaluated by the Administrator responsible for the applicable Contract on an annual basis. " The policy/procedure failed ensure that each service was evaluated by an Administrator using criteria specified in its contractual agreement and failed to indicate a process (direct observation, outcome indicators, process indicators) to validate that services were provided in a safe and effective manner using specific criteria or quality indicators.</p> <p>4. The document Following Administrator Annual Review - Request for Further Evaluation of Contract (approved 11-11) lacked specific and measureable quality indicators to ensure that each service was evaluated objectively and failed to incorporate or reference criteria specified in the</p>		<p>(ADM-LD-110-P) (Attachment # 7).</p> <p>3. The Administrator Contract Services Evaluation Form (ADM-LD-110-a-F) has been revised (Attachment # 6) whereby the Administrator responsible for the applicable hospital service contract shall specific criteria and a process (i.e. direct observation, audit, chart review, process indicators, outcome indicators) upon which the Administrator will evaluate the services provided by collecting and reporting concerning the hospital contracted services to Quality Management for reporting to Quality Council and inclusion in the Hospital Quality/Safety Improvement Plan, which will ensure and validate that contracted services are provided in a safe and effective manner and in compliance with all applicable laws and that any remedial actions are taken to improve services, if recommended by the Quality Council. The Contract Administration Policy (ADM-LD-110-P) has also been revised accordingly (Attachment # 7).</p> <p>4. See response to 3. directly above.</p> <p>5. See response to 2. directly above.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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	<p>contractual agreement.</p> <p>5. During an interview on 2-22-12 at 1020 hours, staff A3 confirmed that the Quality/Safety Council lacked oversight for the contracted services administered through the Office of Legal & Regulatory Affairs.</p>			

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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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 document review, observation and interview, the facility failed to maintain a safe environment that minimized infection exposure and risk for patients and employees.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure OSHA Bloodborne Pathogens Exposure Control Plan ...ICP-10.1. (approved 7-11) indicated the following: " All linen (soiled and contaminated) is laundered by [the contracted laundry service]. " During a tour on 2-20-12 at 1345 hours, a Maytag Neptune washer and dryer without asset identification was observed in the clean linen storage department of the service building. Lint pillows were observed between the washer and dryer, and no handwashing sink or personal protective equipment was available. During an interview on 2-21-12 at 1005 hours, staff A7 confirmed that staff 	S0554	<p>Immediately following this survey, the laundering of the aforementioned linen which consisted of nursery snuggler shoulder pads, was transferred to United Hospital Services, the contracted laundry service. The washer and dryer were taken out of commission and are being disposed of. The Linen/Environmental Services Supervisor has been advised that all policies and procedures related to linen services must go through the Infection Control Committee for approval. (Attachment # 11)</p>	02/27/2012			

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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	<p>was washing newborn baby clothes with equipment purchased in 2011. A7 confirmed that no monitoring was being performed to ensure process safety and effectiveness for the in-hospital laundry services.</p> <p>4. During an interview on 2-21-12 at 1615 hours, staff A4 confirmed that the Infection Control Committee had not been advised of laundry services being performed in the hospital.</p>			

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S0598	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on policy and procedure review, observation, and staff interview, the infection control committee failed to implement its policies related to surgical masks about the neck and the lack of complete hair coverage by skull caps.</p> <p>Findings: 1. at 3:55 PM on 2/20/12, review of the policy and procedure "Dress Code Policy For Perioperative Areas", File No.: ICP-7.2-P indicated: a. under "Policy", it reads: "Personnel will follow dress code to promote high-level cleanliness and hygiene. AREA: Main Surgery, PACU (post anesthesia care unit), CPS, L & D (labor and deliver) Surgical Suites, Cardiac Cath</p>	S0598	The Administrative Director of Surgical Services re-educated all staff regarding the Dress Code Policy for Perioperative Areas on 3/8/12. Skull caps have been removed from the Cath Lab - 3/21/12 The Nurse Manager - Main OR and the Nurse Manager - Cath Lab are responsible for the continued monitoring of compliance with the Dress Code Policy for Perioperative Areas.	03/08/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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	<p>Lab, and Interventional Radiology A. Restricted Area:...Personnel in this area are required to wear full surgical attire and cover all head and facial hair..."</p> <p>b. on page two under "Policy", it reads in item G. "Disposable high filtration masks are required where open sterile supplies or scrubbed personnel are located...3. When removing the mask, handle by strings only and discard immediately. Masks should not be left hanging around neck or tucked into pocket..."</p> <p>c. on page 4 under "Policy", it reads in item P. "Hair must be clean, and neat. <u>All hair</u> must be confined under a cap/hood at all times in restricted and semirestricted areas...Disposable skullcaps that fail to cover all the hair are unacceptable."</p> <p>2. at 9:55 AM on 2/21/12, while on tour of the Surgical area in the company of staff members NM and NN, it was observed that one RN was in the dictation room with a surgical mask about the neck</p> <p>3. interview with staff members NM and NN at 10:00 AM on 2/21/12 indicated facility policy dictates that surgical masks are not to be worn about the neck, but disposed of after each procedure</p> <p>4. at 10:50 AM and 11:03 AM on</p>						

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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	<p>2/21/12, while on tour of the Cath Lab in the company of staff member NM, it was observed that:</p> <ul style="list-style-type: none"> a. a male staff member was standing at the nursing desk with a surgical mask about the neck b. 1 male staff member in the procedure room had a skull cap with hair from the top of the ears to the neckline not covered by the skullcap c. 1 male staff member in the observation area had a skull cap with hair from the top of the ears to the neckline not covered by the skullcap 			

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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S0606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies.</p> <p>Based on policy and procedure review, personnel file review, and staff interview, the infection control practitioner and employee health staff failed to ensure that 1 of 1 contracted PNT (personal needs technician) met the facility policy for immunity to Varicella (P15), and failed to follow up with 1 of 2 contracted open heart nurses (P17) with a negative Hepatitis B titer.</p> <p>Findings: 1. at 12:25 PM on 2/22/12, review of the policy and procedure "Immunizations", File No.: EHS-7-P with a revision date of 4/27/11, indicated: a. on page 3 under "CHICKEN POX",</p>	S0606	<p>The facility policy developed in September, 2011 was intended to be effective January 1, 2012 and applicable to all qualifying healthcare workers onboarded either through employment or contract January 1, 2012. The contracted PNT was onboarded in August 2011 and the Open Heart RN in 2004. All qualifying healthcare workers whose on boarding date precedes January 1, 2012 will be brought up to current recommendations over the next 2 years. The Immunization policy was revised to reflect the January 1, 2012 date. (attached) The Manager of Employee Health Services is responsible for assuring ongoing compliance.</p>	03/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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	<p>it reads: "A verbal history of chicken pox is not acceptable. Health care personnel must have proof of 2 chickenpox vaccines or a titer that shows immunity..."</p> <p>b. on page 3 under "HEPATITIS B", it reads: "...If the titer is negative, a second series is recommended..."</p> <p>2. at 10:40 AM on 2/22/12, review of contracted staff personnel files indicated:</p> <p>a. a contracted psych unit PNT, P15, was hired 8/11 and had signed a self attestation form which indicated a verbal confirmation of having had Varicella (chicken pox)</p> <p>b. a contracted cath lab RN (registered nurse), P17, had documentation in the personnel file of a negative Hepatitis B titer with a letter mailed 2003 with instructions for the staff member to follow up with employee health, but lacked any further notations/documentation of further follow up with the staff member</p> <p>3. interview with staff member NI indicated:</p> <p>a. the newest version of the "Immunization" policy was implemented in 4/11 so that the contracted employee P15, hired 8/11, should not have had a self reported Varicella history form</p> <p>b. it is unknown why there was no further follow up notation related to a</p>						

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	negative Hepatitis B for staff member P17			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012	
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S0610	<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>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation, document review and staff interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary condition as stated in 410 IAC 7-24, Retail Food Establishment Sanitation Requirements, and hospital policies and procedures.</p> <p>Findings included:</p>	S0610	1-2 The kitchen was cleaned thoroughly with special attention given to the areas mentioned in the ISDH survey (including fans, kitchen equipment, floors, and the dishwasher panel). This correction was completed as of 3/5/12. We are implementing a system of Supervisor check-off sheets for each main Supervisor shift (3 per day). At the end of each Supervisor shift,	03/20/2012			

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	<p>1. The production kitchen was toured at 10:15 AM on 2/20/2012. Three of three pedestal fans were observed heavily caked with dirt debris on the blades and the blade guards. The surface tops of assorted kitchen equipment were heavily caked with soil residue and other dirt debris. The kitchen equipment included an convection oven, 3 stand-up refrigerators, and tiled surface of half wall throughout the kitchen. The floor surface under large industrial kitchen equipment throughout the production kitchen was observed with loose soil residue. The Warewashing room was observed with heavy accumulation of food, trash and other dirt debris on the floor throughout the room. There was a panel from the dishwasher lying on the floor heavily caked with a blue liquid chemical from the solution that was used for the multi-conveyor dishwasher. The dirt and soil on some of the equipment had the appearance of being there for a long period of time.</p> <p>2. Weekly and daily cleaning schedules were reviewed for the kitchen and the procedures indicate the floors are to be swept and mopped daily; walls and back splashes are to be wiped down daily; service tops of counters and equipment are to be wiped down daily and/or weekly depending on equipment.</p>		Supervisors will do a walk through in their assigned area and have to check-off that tasks are being completed (this includes the cleaning tasks referred to above). The Supervisor will be responsible for the daily sheets, and to correct any deficiencies he/she observes. This system will be in place by 3/20/12. 3 Utensils were all cleaned the day of the survey 2/20/12. An in-service was given to all food handling Dietetics staff members. The series of in-services was completed on 3/5/12. Supervisors/Managers will be responsible for monitoring this during rounding within the department.				

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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	<p>3. 410 IAC 7-24-295, Equipment Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils states, "Equipment food-contact surfaces and utensils shall be clean to sight and touch; The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris and shall be cleaned at a frequency necessary to preclude accumulation of soil residue." 410 IAC 7-24-431, Physical Structures; Restrictions and Frequency of Cleaning states, "The physical facilities shall be cleaned as often as necessary to keep them clean; Cleaning shall be done during periods when the least amount of food is exposed, such as after closing. This requirement does not apply to cleaning that is necessary due to a spill or other accident."</p> <p>4. At 10:45 AM on 2/20/2012, staff member L3 indicated the equipment was heavily soiled.</p>						

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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S0757	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(8)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(8) Operative note in accordance with 410 IAC 15-1.6-9(c)(7).</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the medical staff and medical records department failed to ensure that a post operative note was completed immediately following the procedure for 1 of 3 patients who had surgery in November and December (pt. N18).</p> <p>Findings:</p> <p>1. at 4:10 PM on 2/22/12, review of the policy and procedure "HIM (health information management) Medical Record Contents Policy", File No.: HIM-CC-401 P, indicated:</p> <p>a. on page 2 under "Observation records and ambulatory surgery records shall document and contain, but not be limited to, the following:...(8) Immediate post op note, if applicable. (9) Operative note if applicable..."</p> <p>2. at 1:00 PM on 2/22/12, review of discharged surgery patient medical records indicated:</p>	S0757	The Immediate Post op Note was inadvertently missed during the medical record review by both the surveyor and the clinical information staff member. A further review conducted post survey revealed that the post-op note was present and had been recorded immediately following the case. The surgeon had documented in the electronic progress note section of the EMR which placed it in the progress note folder. HIM has since moved it to the appropriate Immediate Post op Note folder in the EMR (Attachment # 20)	02/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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	<p>a. pt. N18 had surgery on 12/23/11 for "Exploration and drainage of deep abscess, left chest wall..."</p> <p>b. the operative note for pt. N18 was dictated on 12/29/11</p> <p>c. there was no "immediate post op note" in the medical record for pt. N18</p> <p>3. interview with staff member NB at 2:55 PM on 2/22/12 indicated:</p> <p>a. the surgeon is to hand write/complete a one page brief "immediate post op note" directly after a surgical procedure</p> <p>b. after the brief immediate post op note is completed, the expectation is that the surgeon will then dictate a full operative note within 24 hours of the surgery</p> <p>c. Medical Staff Rules and Regulations do not address the immediate completion of a post op note or the dictation of an op report within 24 hours</p> <p>d. the operative note for pt. N18 does not meet the expectations of the facility</p> <p>e. it is unknown why there was a 6 day delay in the dictation of this report for pt. N18</p>			

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the chief nursing officer failed to implement the policy related to notification of the impending death of 1</p>	S0912	The documentation of the notification of the Organ Procurement Organization was inadvertently missed in the review of the medical record for pt N 19 by the clinical information staff	03/22/2012			

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	<p>of 3 patients to the appropriate agencies (pt. N19).</p> <p>Findings:</p> <p>1. review of the policy and procedure "Anatomical Gifts", File No.: ADM-RI-13-P, indicated:</p> <p>a. under "Procedure", it reads: "I. PROCEDURE 1) All deaths and impending deaths must be reported in a timely manor to the Indiana Donation Alliance Foundation (IDAF) at 1-800-356-7757. An Indiana Organ Procurement Organization (IOPO) representative and/or designated tissue representative will be responsible for...2) The IDAF must be called...4) The determination of medical suitability will be made by an IOPO representative and/or designated tissue representative..."</p> <p>2. at 1:00 PM on 2/22/12, on line review of patient medical records of three persons who died in December and January indicated:</p> <p>a. pt. N19 died on 12/3/11 of multi organ failure and lacked the appropriate completion of forms indicating that IDAF and IOPO were contacted related to the patient's death, or impending death</p> <p>3. interview with staff member NB at 2:55 PM on 2/22/12 indicated:</p> <p>a. after review of the medical record for</p>		<p>member who was assisting the surveyor. Review of the record following the survey did reveal that a narrative note related to the notification of IOPA was documented (attached.)</p>				

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	pt. N19, no nursing documentation could be found related to the contacting of IDA and IOPO, as required by facility policy				

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S1114	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(1)</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>(1) No condition in the facility or on the grounds shall be maintained which may be conducive to the harborage or breeding of insects, rodents, or other vermin.</p> <p>Based on observation and interview, the facility failed to maintain the overall environment and prevent the harborage of rodents or other vermin at the hospital.</p> <p>Findings:</p> <p>1. During a tour of the loading dock area on 2-20-12 at 1345 hours, the following condition was observed: A double exit door absent a bottom extension or sweep with a 3/4 " gap extending across the bottom of the left side.</p> <p>2. During an interview on 2-20-12 at 1355 hours, staff A8 confirmed that the opening failed to prevent rodents or other pests from entering the building.</p>	S1114	The double exit door at the loading dock area was absent of a bottom extension or sweep with a 3/4" gap extending across the bottom of the left side. The side sweep was replaced on 02/21/2012 (Attachment # 22 - Exhibit M5). This has been added to the monthly EOC rounding audit and is the responsibility of the Director of Plant Operations.	02/22/2012			

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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 policy and procedure review, observation, and interview, the facility failed to ensure that no condition was created which might harm patients or employees in regards to expired supplies and lab tubes, dirty microwave ovens in nursing pantry areas, and in relation to the lack of malignant hyperthermia medications, supplies, and training for staff in the cath lab area.</p> <p>Findings: 1. at 3:55 PM on 2/20/12, review of the policy and procedure "Cleaning Hospital Equipment", file No.: NSP-58-P, indicated: a. on page 3 under "Kitchen/Pantry", it reads: "...The following is done by Patient Care Staff...PRN: Toaster, microwave, any dishes that are required to be washed on the unit..."</p>	S1118	<p>1. Microwaves - Following the survey, all patient care managers reviewed with their staff, the responsibilities for cleaning the microwaves. Checking the microwaves for cleanliness has been added to the Infection Control Rounding Sheet and will monitored during the monthly Infection Control Rounds. (Attachment # 23)2. Outdated Supplies - Following the survey, the Manager of Distribution reveiwed with their staff, the reponsibilities for checking monthly for outdated supplies as stated in the Infection Control Policy ICP-1.0-P "General Infection Prevention Practices for Ball Memorial Hospital". (Attachment # 24). All outdated supplies found during survey were removed immediately.3. Cath Lab - Malignant Hypothermia Kit - A Malignant Hypothermia Kit has been provided to the Cath Lab. The</p>	03/20/2012			

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	<p>2. on 2/20/12 at 12:45 PM, while in the company of staff member NG, it was observed in the shared peds/7 north pantry, that the pantry microwave was dirty and needed cleaning</p> <p>3. on 2/21/12 at 1:40 PM, while on tour of the 5th floor med/surg nursing unit in the company of staff member NK, it was observed that the pantry microwave was dirty and needed cleaning</p> <p>4. on 2/21/12 at 2:15 PM, while on tour of the adult psych nursing unit in the company of staff member NL, it was observed that the pantry microwave was dirty and needed cleaning</p> <p>5. at 12:55 PM on 2/21/12, while on tour of the peds nursing unit in the company of staff member NG, it was observed in the treatment room that 2 red topped lab tubes had expired 1/12</p> <p>6. at 1:00 PM on 2/21/12, interview with staff member NG indicated the room is to be restocked and checked weekly for out dated supplies</p> <p>7. at 11:15 AM on 2/20/12, in the company of staff member NE while on tour of the prenatal/obstetric triage room # 4123, two gold topped lab tubes were found to have expired 8/11</p>		Malignant Hyperthermia policy was revised to include the Cath Lab in it's scope. (Attachment # 25). An on-line educational module has been created and is available to staff to be completed by Mar 30, 2012.		

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	<p>8. interview with staff member NE at 11:20 AM on 2/20/12, indicated the triage rooms are "restocked weekly and expiration dates are to be checked at that time"</p> <p>9. at 10:20 AM on 2/21/12, while on tour of the obstetric surgical suites area in the company of staff members NC and NQ, it was observed in the Malignant Hyperthermia kit that the following items had expired:</p> <ul style="list-style-type: none"> a. one Edwards Life Sciences pressure monitoring kit that exp. 10/10 b. one Edwards Life Sciences Swan-Ganz kit that expired 3/11 <p>10. interview with staff member NC at 10:25 AM on 2/21/12, indicated these items have been difficult to procure--back ordered, no longer made, etc.</p> <p>11. at 3:15 PM on 2/21/12, while on tour of the rehab unit in the company of staff member NP, it was observed in the clean utility room that one blue top lab tube expired 1/11 and one expired on 8/11</p> <p>12. at 11:15 AM on 2/21/12, while touring the cath lab area, an interview with staff member NR indicated:</p> <ul style="list-style-type: none"> a. there are patients who undergo a general anesthesia sedation during certain 			

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	<p>cath lab procedures</p> <p>b. there is no malignant hyperthermia kit with Dantrolene present in the cath lab department</p> <p>c. there has been no cath lab staff training in how to care for a patient who might suffer from malignant hyperthermia</p> <p>d. the nurse manager had not given thought to the idea that malignant hyperthermia might be an issue for general anesthesia patients in their area</p> <p>13. at 4:00 PM on 2/21/12, interview with staff member NB indicated:</p> <p>a. there is no policy or procedure related to the rotation of supplies and lab tubes on nursing units</p> <p>b. there is no policy or procedure related to the checking of supply expiration dates on the nursing units</p>				

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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S1160	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on observation and interview, the facility failed to maintain one of two negative airflow isolation rooms located in the emergency department (ED) in good working order.</p> <p>Findings:</p> <p>1. During a tour of the ED on 2-20-12 at 1145 hours, in the presence of staff A8 and A12, the following condition was observed: The visual indicator for airborne isolation room 29 failed to indicate a fault condition (red light) when the system was activated and the door was held open.</p> <p>2. During a follow-up interview on 2-21-12 at 1120 hours, staff A8 indicated that the airflow indicator failed to confirm a fault (red light) of the negative airflow ventilation due to a sensor deactivation</p>	S1160	<p>During a follow interview with the Director of Plant Operations, he confirmed the fault of the negative airflow ventilation was due to a sensor deactivation and provided documentation that the condition had been corrected (Attachment # 26 - Exhibit M6). Infection Control Policy "Negative Pressure Rooms (location and testing) ICP-3.7A-P states that "Negative Pressure Rooms used for airborne isolation must be verified and documented in patient care record as properly functioning, prior to placing patient in negative pressure room and each shift until isolation is discontinued." (Attachment # 27) Checking of negative pressure rooms is also included in the EOC/Infection Control Rounds. (Attachment # 23))</p>	02/22/2012

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	and provided documentation that the condition had been corrected.			

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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S1164	<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 observation and interview, the facility lacked documentation of preventive maintenance (PM) on all equipment for 7 items observed on tour at the hospital and one off-site.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a tour on 2-20-12 at 1215 hours, in the radiology department housekeeping closet NT-1091A, the following equipment was observed: An Advance 170 rpm electric floor buffer with an asset tag #4910. Staff A8 was requested to provide documentation of PM and none was provided prior to exit. During an interview on 2-21-12 at 1035 hours, staff A8 confirmed that P was 	S1164	<p>There shall be evidence of preventive maintenance on all equipment. During a tour of the radiology department, an Advance 170 rpm electric floor buffer with an asset tag #4910 had no evidence of a preventive maintenance check. The Director of Plant Operations is working on developing a preventive maintenance program for all the environmental services equipment. The Director is coordinating activities Maintenance staff, Environment services staff, and Biomedical Services staff. The maintenance staff has started performing preventive maintenance checks on all environmental services equipment. The Maytag washer in the service building did not have an asset tag or any evidence of a preventive maintenance check. A Maintenance Supervisor is adding the washer to the inventory and setting up a preventive</p>	03/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012
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	<p>not being performed on the buffer.</p> <p>3. During a tour on 2-20-12 at 1340 hours, in the service building hall adjacent to the loading dock, the following equipment was observed: A Maytag washing machine without an asset tag. Staff A8 confirmed that the equipment was not receiving PM.</p> <p>4. During a tour on 2-20-12 at 1340 hours, in the laundry department, the following equipment was observed: A Maytag washer and dryer without asset tags. Staff A8 confirmed that the equipment was not receiving PM.</p> <p>5. During a tour on 2-12-12 at 0915 hours, in the outpatient pediatric rehab department, the following equipment was observed: 3 wooden adjustable benches without asset tags. The benches had padded vinyl covering on top with worn and torn fabric corners. Staff A17 confirmed that the benches and equipment at the department were not receiving PM.</p> <p>6. During a tour on 2-21-12 at 1400 hours, in the mental health unit, the</p>		<p>maintenance schedule. The Maytag washer and dryer in the laundry department had no asset tag or any evidence of a preventive maintenance check. The washer and dryer have been removed from the hospital and destroyed. The outpatient pediatric rehabilitation department at Kenmore had 3 wooded adjustable benches without asset tags. The benches and the non-medical equipment in the department were not receiving preventive maintenance checks. The Director of Plant Operations is developing a preventive maintenance program for the equipment at the Pediatric Rehabilitation Department. The Maytag washer and dryer in the mental health unit did not have an asset tag or any evidence of a preventive maintenance check. A Maintenance Supervisor is adding the washer and dryer to the inventory and setting up a preventive maintenance schedule.</p>		

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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	<p>following equipment was observed: A Maytag washer and dryer without asset tags.</p> <p>7. During an interview on 2-22-12 at 1015 hours, staff A8 confirmed that the laundry equipment observed at the mental health unit was not receiving PM.</p>			

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S1168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, observation and interview, the hospital failed to ensure that defibrillator inspection and testing was performed according to the manufacturer's recommendations at the facility.</p> <p>Findings:</p> <p>1. The policy/procedure Cardiopulmonary Emergency (Medical Alert) (approved 1-12) lacked a provision indicating that the manual defibrillators will be discharged at least in accordance with the manufacturer ' s recommendations.</p> <p>2. During a tour of the Emergency Department on 2-20-12 at 1145 hours, (2) Lifepak 12 monitor/defibrillators were observed in the Pyxis medstation area</p>	S1168	<p>Policy ADM-TX-7-P " Cardiopulmonary Emergency (Medical Alert)" (Attachment # 29); NSS-22-P "Maintenance of Code Cart Integrity" Attachment # 30; NSS-22-F "Nursing Unit Daily Code Cart Checklist", Attachment # 31. have been revised to contain a provision indicating that the manual defibrillators are to be discharged in accordance with the manufacturer's recommendations. All staff were notified and the Daily Code Cart Checklist on the carts were removed and replaced with the revised checklist. The Nurse Managers are responsible for assuring that their assigned staff are carrying out and documenting this code cart checks.</p>	03/07/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>adjacent to the Emergency Code Cart featuring a Lifepak 20 monitor/defibrillator. The document Nursing Unit Daily Code Cart Checklist located on top of the Code Cart indicated the following: "Defibrillator...Daily Check (see card)...[and]...Transport Defibrillator...(see card)." No card was present on the clipboard containing the daily code cart checklist. The checklist failed to incorporate or attach the manufacturer's Operators Checklist (found in the Operators Manual under the corresponding chapter heading Maintaining the Equipment) for both models of monitor/defibrillators.</p> <p>3. During an interview on 2-20-12 at 1145 hours, staff A18 confirmed that the policy/procedure and Daily Code Cart Checklists failed to ensure that the equipment was checked in accordance with manufacturer ' s recommendations.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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S1172	<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>(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 policy and procedure review, observation, and interview, the facility failed to implement its policy related to weekly cleaning of pantry refrigerators in 4 areas toured (Pediatrics/7 North; 6th floor Ortho; Adult psych on 2nd floor; and Rehab).</p> <p>Findings: 1. at 3:55 PM on 2/20/12, review of the policy and procedure "Cleaning Hospital Equipment", file No.: NSP-58-P, indicated: a. on page 3 under "Kitchen/Pantry", it reads: "the following is done by Environmental Services:...Weekly: Inside of refrigerator..."</p>	S1172	Refrigerators were immediately cleaned on the units in question (2/21/12). A refrigerator cleaning log has been placed on each refrigerator and will be kept up by the EVS employee cleaning that unit on the assigned cleaning day. This cleaning includes the inside and outside of the refrigerator. Supervisors are responsible to double check logs when rounding on units.	03/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303		
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	<p>2. at 10:25 AM on 2/21/12, review of various nursing unit daily worksheets by housekeeping staff indicated the weekly cleaning of refrigerators is not noted as a requirement, nor was it documented by housekeeping staff as having been done</p> <p>3. review of the "Environmental Services Instructions-Duties Unit Cleaner Procedure Step by Step" form and the "Environmental Services Instructions-Duties Unit Cleaner 3:30 and 4 P.M." form indicated that weekly cleaning of the pantry refrigerators was not addressed (only patient room cleaning was addressed in both documents)</p> <p>4. at 12:45 PM on 2/20/12, while on tour of the Pediatric unit in the company of staff member NG, it was observed that the pantry refrigerator, shared with the 7 North med/surg nursing unit, was dirty with dried liquids on the lower shelf and both lower vegetable drawers were dirty both inside and behind the drawers</p> <p>5. interview with staff member NG indicated the cleaning of the refrigerator was a housekeeping duty and most likely had been overlooked with the refrigerator being "shared" by two units</p> <p>6. at 2:05 PM on 2/21/12, while on tour</p>				

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303		
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	<p>of the 6th floor Ortho nursing unit in the company of staff member NO, it was observed that the pantry refrigerator was dirty at the back of the lower shelf in the slotted area of the shelf</p> <p>7. at 2:20 PM on 2/21/12, while on tour of the 2nd floor Adult Psych nursing unit in the company of staff member NL, it was observed that the patient refrigerator had one small bowl of uncovered pears and one uncovered bowl of jello--neither bowl was marked with a patient name, room number, etc.</p> <p>8. at 2:25 PM on 2/21/12, staff member NL indicated only covered, labeled foods should be present in the patient refrigerator</p> <p>9. at 3:20 PM on 2/21/12, while on tour of the Rehab nursing unit in the company of staff member NP, it was observed that the pantry refrigerator door shelves were dirty with spilled applesauce and the lower vegetable drawers were dirty</p> <p>10. interview with staff members NB and NJ at 10:35 AM on 2/22/12 indicated it cannot be determined: a. that housekeeping staff are aware of the policy related to weekly cleaning of pantry refrigerators b. there is no documentation that</p>				

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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	indicates when pantry refrigerators on the Peds unit, the Ortho unit, or the Rehab unit were last cleaned			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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S1180	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(f)(1)</p> <p>(f) The safety management program shall include, but not be limited to, the following:</p> <p>(1) An ongoing hospital-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the safety committee.</p> <p>Based on policy and procedure review, EOC (environment of care) monthly facility assessment checklist review, observation and staff interview, the safety committee failed to implement its policy related to cardboard boxes stored on the floor in one unit (adult psych).</p> <p>Findings:</p> <p>1. at 12:25 PM on 2/22/12, review of the policy and procedure "Storage of Sterile and Clean Supplies", File No.: SSP-CPS-190-P, indicated:</p> <p>a. on page 3 it reads: "...Packages should be kept 10 inches above the floor and 18 inches away from the sprinkler head,..."</p> <p>2. at 12:25 PM on 2/22/12, review of the monthly facility tool titled: "Indiana University Health Ball Memorial Hospital Departmental and Facility EOC Assessment" indicated:</p> <p>a. in the second section "Safety</p>	S1180	Supplies found on the floor in the housekeeping storage closet were immediately removed from the floor. Staff were reminded of the policy of not storing items on the floor. Compliance with this is monitored by the Safety Coordinator during monthly EOC rounds. The Unit/Department manager is responsible for the maintaining compliance with this policy.	02/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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	<p>Management", item #11 reads: "Are all supplies and cardboard boxes stored off the floor?"</p> <p>3. at 2:30 PM on 2/21/12, while on tour of the adult psych nursing unit in the company of staff member NL, the following was observed in the housekeeping storage closet:</p> <p>a. two large (approx. 4 foot square) cardboard boxes of paper towels were being stored on the floor</p> <p>4. interview with staff member NJ at 12:25 PM on 2/22/12 indicated:</p> <p>a. monthly rounds are conducted on every nursing unit utilizing the tool mentioned in 2. above</p> <p>b. it is against facility policy to have cardboard boxes stored on the closet floor on the psych unit</p>			

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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S1216	<p>410 IAC 15-1.5-9 RADIOLOGIC SERVICES 410 IAC 15-1.5-9(b)(1)(A)(B)(i)(ii)(iii)(iv)(v)(C)</p> <p>(b) The services that use ionizing radiation shall not compromise the health, safety, and welfare of patients or personnel in accordance with federal and state rules, as follows:</p> <p>(1) Proper safety precautions shall be maintained against radiation hazards in accordance with the hospital's radiation and safety program as developed by the radiation safety officer. This includes, but is not limited to, the following:</p> <p>(A) Adequate shielding for patients, personnel, and facilities. (B) Procedures for monitoring: (i) skin dosage; (ii) radionuclide contamination; (iii) quality control; (iv) technique charts, where applicable; and (v) handling of hazardous materials. (C) Appropriate storage, use, and disposal of radioactive materials.</p> <p>Based on document review, observation and interview, the facility failed to follow its policy/procedure and ensure that safety shielding was periodically inspected to protect the health and safety of radiology personnel .</p> <p>Findings:</p>	S1216	All aprons have been evaluated. The responsibility for evaluating aprons at least annually is the responsibility of the Managers of the departments that own the aprons. Any apparel found to be in need of radiographic evaluation will be brought to radiology by the responsible department along with any applicable tracking forms for completion. The director of Radiology is responsible for	03/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303		
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	<p>1. The policy/procedure Radiology Lead Apparel Policy (reviewed 1-12) indicated the following: " Lead apparel shall be evaluated at least annually. "</p> <p>2. During a tour of the department on 2-20-12 at 1250 hours, one maroon lead apron with the identifier CCU 4P was selected to validate the system for periodic inspection of protective materials. Staff A19 was requested to provide documentation of testing for the apron.</p> <p>3. During an interview on 2-20-12 at 1550 hours, staff A19 confirmed that no testing had been performed for the sample apron since 2010.</p>		ongoing monitoring of this process and will report at least annually to the Radiation Safety Committee.		

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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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S2120	<p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8 (c)(2)</p> <p>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:</p> <p>(2) There shall be a history and physical workup in the chart of every patient prior to surgery, except in emergencies. If this has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting physician, which includes vital signs, allergies, and appropriate data.</p> <p>Based on policy and procedure review, surgical patient medical record review, and staff interview, the medical staff failed to ensure that a history and physical was completed for 1 of 3 patients prior to surgery (pt. N17).</p> <p>Findings: 1. at 4:10 PM on 2/22/12, review of the policy and procedure "HIM (health information management) Medical Record Contents Policy", File No.: HIM-CC-401 P, indicated: a. on page 2 under "Observation records and ambulatory surgery records shall document and contain, but</p>	S2120	IU Health Ball Memorial Hospital has a contract to provide a series of services to Integra, a free-standing LTAC which rents space in the Ball Hospital building. As part of the contract, surgical services are provided on a fee for service basis. The Integra patient registers at Ball Memorial as a Contract - Integra patient for the purposes of facilitating documentation in the surgical electronic record, and incurring charges. The primary medical record is maintained in the Integra paper record. This patient's H & P and daily progress notes which would cover the required H & P update were brought to surgery with the patient	03/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303		
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	<p>not be limited to, the following:...(3) Medical history and description of the patient's condition and pertinent physical findings. (4) H&P (history and physical) Update if H&P is completed prior to date of service..."</p> <p>2. at 1:00 PM on 2/22/12, review of discharged surgery patient medical records indicated:</p> <p>a. pt. N17 had out patient surgery for a tracheostomy placement on 11/9/11</p> <p>b. there was no history and physical in the electronic medical record for pt. N17</p> <p>3. interview with staff member NB at 2:55 PM on 2/22/12 indicated:</p> <p>a. pt. N17 was an inpatient on the contracted long term acute care (LTAC) facility located within this hospital and came to this facility only for out patient surgery (after recovery, returned to the LTAC)</p> <p>b. there was only one electronic record for pt. N17, which was the LTAC chart</p> <p>c. there was no H & P in the medical record for pt. N17 as is required prior to a patient having surgery</p>		and then returned to Integra upon release from PACU. As IU Health Ball Memorial is providing contracted services to Integra, this patient is an Integra patient and not a Ball patient.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303			
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S2122	<p>410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8 (c)(3)</p> <p>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:</p> <p>(3) A properly executed informed consent form for the operation shall be in the patient's chart before surgery, except in extreme emergencies.</p> <p>Based on policy and procedure review, surgical patient medical record review, and staff interview, the facility failed to ensure that a surgical consent was completed for 1 of 3 discharged surgical patients (Pt. N17).</p> <p>Findings: 1. at 4:10 PM on 2/22/12, review of the policy and procedure "HIM (health information management) Medical Record Contents Policy", File No.: HIM-CC-401 P, indicated: a. on page 2 under "Observation records and ambulatory surgery records shall document and contain, but not be limited to, the following:...(2) Appropriate general consents and informed consents..." b. on page 3 under "Outpatient records shall document and contain, but not be</p>	S2122	<p>IU Health Ball Memorial Hospital has a contract to provide a series of services to Integra, a free-standing LTAC which rents space in the Ball Hospital building. As part of the contract, surgical services are provided on a fee for service basis. The Integra patient registers at Ball Memorial as a Contract - Integra patient for the purposes of facilitating documentation in the surgical electronic record, and incurring charges. The primary medical record is maintained in the Integra paper record. This patient's H & P and daily progress notes which would cover the required H & P update were brought to surgery with the patient and then returned to Integra upon release from PACU. As IU Health Ball Memorial is providing contracted services to Integra, this patient is an Integra patient and not a Ball patient.</p>	02/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2012
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303		
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	<p>limited to, the following:" indicated: "Identification data. (1) Appropriate general consent and Informed consent..."</p> <p>2. at 1:00 PM on 2/22/12, review of discharged surgery patient medical records indicated:</p> <p>a. pt. N17 had out patient surgery for a tracheostomy placement on 11/9/11</p> <p>b. the medical record lacked a signed consent for treatment form</p> <p>c. the medical record lacked a signed consent for the surgical procedure performed on 11/9/11</p> <p>3. interview with staff member NB at 2:55 PM on 2/22/12 indicated:</p> <p>a. pt. N17 was an inpatient on the contracted long term acute care (LTAC) facility located within this hospital and came to this facility only for out patient surgery (after recovery, returned to the LTAC)</p> <p>b. there was only one electronic record for pt. N17, which was the LTAC chart</p> <p>c. nursing documented electronically, during the surgical time out, that the surgical site was correct based on the consent form</p> <p>d. there was no consent for admission and treatment form, nor a signed surgical consent form for pt. N17 to be found in the medical record, as is required prior to a patient having surgery</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150089	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 UNIVERSITY AVE MUNCIE, IN 47303
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