

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152008	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL- INDIANAPOLIS SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 607 GREENWOOD SPRINGS DRIVE GREENWOOD, IN 46143
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S 0000 Bldg. 00	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 006218</p> <p>Survey Date: 10-31-2016 to 11-02-2016</p> <p>QA: 12/19/16 jlh</p>	S 0000	POC complete	
S 0270 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review quarterly reports of management operations for calendar year 2015, for 1 of 4 quarters.</p>	S 0270	Deficiency Correction: A Governing Board committee meeting was completed and included discussions on hospital quality assurance and performance improvement data for 3rd quarter, 2015.	12/08/2016

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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S 0308 Bldg. 00	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of governing board minutes for calendar year 2015 indicated there was no review of quality activities for the 3rd quarter. 2. Interview of employee #A3, Director of Quality Management, on 11-02-2016 at 11:25 am, confirmed the above and no other documentation was provided prior to exit. <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</p>	S 0308	<p>Deficiency Prevention: A specific quality assurance and performance improvement data line item was placed on the ad-hoc Governing Board meeting agenda so that both the bi-annual governing board meetings and any additional ad-hoc meeting will address hospital quality assurance and performance improvement ensuring quality data is discussed quarterly at a minimum.</p> <p>Responsible Party: The CEO and DQM will be responsible for ongoing compliance.</p> <p>Correction Date: 12/8/2016</p> <p>Deficiency Correction: The</p>	03/10/2017

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	<p>interview, the hospital failed to orient 3 of 24 employees to applicable overall facility policies and 3 of 24 employees to applicable department policies, per facility policy.</p> <p>Findings include:</p> <p>1. Review of hospital policy H-ML 11-001, entitled Hospital-Wide Education Plan, Release Date 08/2014, indicated "2. Provide General Hospital Orientation (GHO) for all new employees, students and agency contract staff."</p> <p>2. Review of hospital policy H-ML 11-001, entitled Hospital-Wide Education Plan, Release Date 08/2014, indicated "3. Department specific orientation is achieved in collaboration with appropriate department director/designee."</p> <p>3. Review of 24 personnel files indicated files P7, occupational therapist, P8, physical therapist, and P9, speech therapist did not contain any documentation of applicable overall facility policies.</p> <p>4. In interview, on 11-02-2016 at 1:30 pm, employee #A1, Market Chief Operating Officer, confirmed the above</p>		<p>Clinical Educator conducted a file review of all current employees, students and contracted staff members. Any employee that did not attend the general hospital orientation or department specific orientation will be required to attend the next scheduled session.</p> <p>Deficiency Prevention: All newly hired employees including students and contracted staff will be required to attend the general hospital in addition to any department specific orientation. Employee education and health files for contracted staff will now be stored onsite. A review of all current employees, contracted staff and student files will be conducted annually to ensure compliance.</p> <p>Responsible Party: The Clinical Educator will be responsible for ongoing compliance.</p> <p>Correction Date: 3/10/2017.</p>	

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S 0312 Bldg. 00	<p>and no other documentation was provided prior to exit.</p> <p>5. Review of 24 personnel files indicated employees P8, P9 and Nursing personnel #N7, nurse, did not contain any documentation of department specific orientation.</p> <p>6. In interview, on 11-02-2016 at 1:30 pm, employee #A1, confirmed the above for department specific orientation of employees P8 and P9 and no other documentation was provided prior to exit.</p> <p>7. In interview, on 11/2/2016 at 1400 hours, staff member #N8, Chief Clinical Officer, indicated that documentation of department specific orientation for nursing staff #N7 could not be located.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</p>			

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	<p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to conduct a performance evaluation for 1 of 4 contracted employee files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of a document entitled Conducting a Performance Evaluation, reviewed 05-11-2016, indicated "...annual evaluation ... " Review of 4 contracted employee personnel files indicated file P8, physical therapist, contained a performance evaluation conducted by an individual employed by the contractor and did not contain an evaluation conducted by an authorized direct employee of the facility. In interview on 11-02-2016 at 1:30 pm, employee #A1, Market Chief Executive Officer, indicated the contract for the services of P8 did not include the contractor had the right to perform the 	S 0312	<p>Deficiency Correction: KHIS department heads will conduct a file review of all current employees and contracted staff members. Any employee evaluation that has been completed for the year 2017 will be forwarded to the CEO and CCO for review and signature.</p> <p>Deficiency Prevention: KHIS department heads will forward all completed employee evaluations to the CEO or CCO for review and signature prior to final submission. A review of all current employees, contracted staff files will be conducted annually to ensure compliance.</p> <p>Responsible Party: The Clinical CEO and CCO will be responsible for ongoing compliance.</p> <p>Correction Date: 3/8/2017.</p>	03/08/2017

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S 0318 Bldg. 00	<p>evaluation. Employee #A1 confirmed the evaluation was not conducted by an authorized direct employee of the facility, nor was the evaluation reviewed by an authorized direct employee of the facility. No other documentation was provided prior to exit</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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: (F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and interview, 3 of 24 employee files examined lacked documentation of current CPR training.</p> <p>1. Review of nursing personnel files on 11/02/2016 at 1300 hours indicated 2 of 15, (numbers N5 and N7), had CPR</p>	S 0318	<p>Deficiency Correction: The Clinical Educator will conduct a file review of all current employees, and contracted employees. Any employee that is missing the required certification will be removed from the schedule and placed into the next available session. Deficiency Prevention: Education and health files for employees</p>	03/10/2017

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S 0330 Bldg. 00	<p>competencies that were expired.</p> <p>2. In interview on 11/02/2016 at 1330 hours, employee #NO 8 (Chief Clinical Officer), agreed with these findings.</p> <p>3. Review of administrative personnel files indicated file P8, physical therapist, had documentation of CPR competency that expired February, 2016.</p> <p>4. In interview, on 11-02-2016 at 1:30 pm, employee #A1, Market Chief Operating Officer, confirmed the expiration and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</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>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation</p>				<p>and contracted employees will now be stored onsite. A review of all current employees and contracted employee files will be conducted annually to ensure compliance.</p> <p>Responsible Party: The Clinical Educator will be responsible for ongoing compliance.</p> <p>Correction Date: 3/10/2017.</p>		

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	<p>in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review and interview, the hospital failed to maintain personnel records which included evidence of compliance with annual required training for 5 of 9 personnel files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of hospital policy H-ML 11-001, entitled Hospital-Wide Education Plan, Release Date 08/2014, indicated "<i>Department Directors/Managers</i> [are] Responsible for ensuring compliance with required annual training." Review of 9 personnel files indicated files P5, environmental services, P6, maintenance, P7, occupational therapist, P8, physical therapist, and P9, speech therapist, did not have current documentation of required annual training. In interview, on 11-02-2016 at 1:30 pm, employee #A1, Market Chief Executive Officer, confirmed all the above and no further documentation was 	S 0330	<p>Deficiency Correction: The Clinical Educator will conduct a file review of all current employees and contracted staff employees. Any employee that did not attend the annual education session will be required to attend the next scheduled session in August, 2017.</p> <p>Deficiency Prevention: All employees and contracted employees will attend the annual hospital education in addition to any department specific annual education required. Employee education and health files for contracted staff will now be stored onsite. A review of all current employees and contracted employees will be conducted annually to ensure compliance.</p> <p>Responsible Party: The Clinical Educator will be responsible for ongoing compliance.</p> <p>Correction Date: 3/10/2017</p>	03/10/2017

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S 0358 Bldg. 00	<p>provided prior to exit.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(5)(A)(B)(C)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>(5) Ensure policies are established to cover physician limited practice problems that may include, but are not necessarily limited to, the following:</p> <p>(A) Impaired physicians. (B) Criminal checks. (C) Disciplinary action.</p> <p>Based on document review and interview, the hospital failed to ensure a policy was established to cover whether criminal background checks will or will not be performed on physicians.</p> <p>Findings include:</p> <p>1. Review of facility policy H-ML 05-001 PRO, entitled Medical Staff Credentialing, Release Date 2/2014, did not indicate whether a criminal background check was or was not required to be performed on physicians.</p> <p>2. In interview, on 11-01-2016 at 2:25</p>	S 0358	<p>Deficiency Correction: There will be a local addendum created that specifically indicates that a criminal background check is performed during the credentialing process. This addendum will be reviewed and approved during MEC and Governing Board.</p> <p>Deficiency Prevention: The deficiency correction will address deficiency correction.</p> <p>Responsible Party: The Director of Quality Management will be responsible for ongoing compliance.</p> <p>Correction Date: 3/10/2017</p>	03/10/2017

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S 0554 Bldg. 00	<p>pm, employee #A3, Director of Quality Management, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the facility failed to ensure a safe environment for patients by ensuring clean supplies and equipment were protected from contamination.</p> <p>Findings included:</p> <p>1. On 10-31-2016 at 1:15 pm, in the presence of employee #A4, Director Plant Operations, it was observed in a general storage area, there was 1 case of Replete Fiber Nutritional Supplement, containing 4 bags each of 1.5 liters, on a shelf with an expiration date of 10-25-2016. The case was not marked to not use nor was it stored in an area of expired items.</p>	S 0554	<p>Deficiency Correction: A hospital wide environmental round will be conducted by the infection prevention nurse, plant operations, housekeeping manager and food service manager with a focus on the areas specifically identified in the SOD. Any deficiency was addressed and corrected during rounding.</p> <p>Deficiency Prevention: An environmental rounding team will be created and will include the Infection Prevention Nurse, Food Service Manager, Housekeeping Manager, Director of Plant Operations and CEO, CCO or DQM. Hospital environmental rounds will be conducted monthly utilizing a standardized checklist. Any concerns identified during</p>	03/10/2017

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	<p>2. On 10-31-2016 at 1:15 pm, in the presence of employee #A4, it was observed in the lobby/reception area, there were 12 of 14 overhead lights that had dust/dirt in them.</p> <p>3. During a tour of the SCU on 11/1/2016 at 1120 hours, accompanied by staff member #NO5, nursing manager, it was noted that the code cart and defibrillator had a coating of dust on them, three pantry drawers had spilled coffee and crumbs in them and the refrigerator had dried spilled substance and crumbs on the shelves. Also 2 of 2 medicine server cabinets in rooms #6 and #7 were dusty inside, even though one room was marked as clean and ready for an admission.</p> <p>4. During a tour of the Med-Surg Unit on 11/1/2016 at 1150 hours, accompanied by staff member #NO5, nursing manager, it was noted that two pantry drawers had spilled coffee in them and the refrigerator shelves were noted to have spilled substances on the shelves. Also the medicine server cabinets, 2 of 2 examined, in rooms #205 and #220, also a cleaned room, had dusty interior shelves in the medicine server.</p> <p>5. During a tour of the Dialysis Room on</p>		<p>rounding will be documented and a completion date provided. Completion progress will be discussed during the daily flash meeting.</p> <p>Responsible Party: The Infection Prevention nurse will be responsible for ongoing compliance.</p> <p>Correction Date: 3/10/2017</p>	

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S 0952 Bldg. 00	<p>11/1/2016 at 1200 hours, accompanied by staff member #NO5, nursing manager, it was noted that 4 of 4 dialysis machines and 4 dialysis carts had dust on the tops, shelves and backs of them.</p> <p>The dialysis supply room had 7 boxes of Natural Lyte concentrated dialysis solution sitting on the floor. The floor of the supply room had a layer of dust and debris on the floor. A bag of 2 disposable pillows and two dining server trays were also on the floor.</p> <p>One dialysis machine had an opened gallon bottle of dialysis vinegar for cleaning on the bottom shelf, was not dated, had no cap on it, and two machine tubes were sticking out of the bottle.</p> <p>6. On 11/2/2016 at 1500 hours, staff member #NO5 agreed with the above findings indicated that they needed attention to correct them.</p>			
	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)			

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	<p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on document review and interview, the facility failed to follow approved medical staff policies and procedures for the administration of two of six transfusions.</p> <p>Findings included:</p> <p>1. On 11/01/16 review of transfusion records revealed:</p> <p>a. Transfusion #2 (T#2) time documentation indicated the transfusion was started at 1500 but documentation indicated the blood was not removed from the temperature controlled cooler until 1510. Blood must be infused within 4 hours of removal from the cooler per facility policy/procedure and transfusion cannot be started before removal from the cooler.</p> <p>b. Transfusion #5 (T#5) had no documentation of the time the blood was removed from the cooler which does not follow policy/procedure.</p>	S 0952	<p>Deficiency Correction: Nursing staff will be provided education on the documentation process when checking out blood products and instructed to utilize the EMR exclusively for any time stamp during the administration process to ensure there is consistency in the administration timeline.</p> <p>Deficiency Prevention: The Nurse Manager will review any blood products administration daily Monday thru Friday. Any blood products that are administered during the weekend will be reviewed the following Monday. Any discrepancy in documentation will be discussed with specific staff member related to the occurrence and performance improvement provided as needed.</p> <p>Responsible Party: The CCO will be responsible for ongoing compliance.</p> <p>Correction Date: 3/8/2017</p>	03/08/2017

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NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL- INDIANAPOLIS SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 607 GREENWOOD SPRINGS DRIVE GREENWOOD, IN 46143
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 1028 Bldg. 00	<p>2. In interview on 11/01/16 at 12:30 p.m. SP (Staff Person) #2 (Registered Nurse) confirmed the above missing documentation.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent.</p> <p>Based on observation and interview, the facility failed to maintain security and authorized access to a restricted medication in one instance.</p> <p>1. While on tour of SCU medicine room on 11/01/2016 at 1130 hours accompanied by staff member #N5 (Nursing Manager) , it was noted the lock for the drawer where Propofol bottles are stored was broken, risking unauthorized persons being able to access the drug.</p>	S 1028	<p>Deficiency Correction: Pharmacy removed the medication and plant operations were notified of the faulty lock immediately upon its discovery.</p> <p>Deficiency Prevention: Controlled substances were removed from the drawers and will now be stored in the electronic medication delivery system. Education will be provided to clinical staff on identifying faulty equipment and initiating a repair work order.</p> <p>Responsible Party: The Director of Plant Operations is responsible for ongoing compliance.</p>	03/08/2017

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S 1125 Bldg. 00	<p>2. On 11/01/2016 at 1130 hours, staff member #N5 agreed with the finding and indicated the lock should be repaired.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(B)</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>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(B) Operational and maintenance control records shall be established and analyzed periodically. These records shall be readily available on the premises.</p> <p>Based on document review and interview, the facility failed to document operational and maintenance control records having been analyzed for 1 of 7 systems of equipment.</p> <p>Findings include:</p> <p>1. On 10-31-2016 at 10:00 am, employee #A1, Market Chief Executive Officer, was requested to provide documentation</p>	S 1125	<p>Correction Date: 3/8/2017</p> <p>Deficiency Correction: Edge Mechanical was contacted and requested to perform a boiler control analysis. Deficiency Prevention: Edge Mechanical will now perform an analysis on the boiler control records quarterly as part of the scheduled maintenance program. Responsible Party: The Director of Plant Operations is responsible for ongoing compliance.</p>	03/08/2017

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S 1160 Bldg. 00	<p>of the operational and maintenance control records for the boiler having been analyzed.</p> <p>2. In interview, on 11-02-2016 at 10:50 am, employee #A4, Director Plant Operations, confirmed there was no documentation for the boiler control records having been analyzed, and no other documentation was provided prior to exit.</p> <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 document review and interview, the facility failed to have a policy to regularly maintain 9 pieces of patient care equipment in accordance with the manufacturer's recommendations, and failed to have a waiver to regularly service and maintain patient care equipment in 1 instance.</p> <p>Findings include:</p> <p>1. On 05-16-2016 at 10:30 am, employee</p>	S 1160	<p>Correction Date: 3/8/2017</p> <p>Deficiency Correction: UHS was contacted and requested to perform PM on the 9 pieces of equipment identified in the SOD using manufactures guidelines. Deficiency Prevention: The equipment listed in the SOD was placed on the UHS equipment detail to ensure schedule PM is performed using manufactures guidelines. If the manufactures guidelines are not available, a risk assessment will be performed by UHS. The risk assessment will be forwarded to the ISDH for review</p>	03/10/2017

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	<p>#A6, Facilities Services, was requested to provide documentation of a policy to conduct preventive maintenance for a defibrillator, a dietary dishwasher, an electrocardiograph machine, an emergency code call system, a floor scrubber, a hydrocollator, a medication pump, and a patient bed.</p> <p>2. On 10-02-2016 at 1:30 pm, while on facility tour, employee #A4, Director Plant Operations, was requested to provide documentation of a policy to conduct preventive maintenance for a dishwasher in the occupational therapy area.</p> <p>3. In interview on 11-02-2016 at 10:50 am, employee #A4 indicated there was no policy available on all the above-requested equipment and no other documentation was provided prior to exit.</p> <p>4. In interview, on 11-01-2016 at 12:35 pm, employee #A4 indicated the facility's contracted provider for biomedical engineering service used a risk assessment program to conduct preventive maintenance. The employee was requested to provide documentation of contractor use of and waiver by the State to have such a program</p>		<p>and waiver to utilize the risk assessment. The risk assessment and ISDH waiver will be filled onsite and available for regulatory purposes.</p> <p>Responsible Party: Party: The Director of Plant Operations is responsible for ongoing compliance.</p> <p>Correction Date: 3/10/2017</p>	

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S 1162 Bldg. 00	<p>5. Review of an email from #A6, contractor, to employee#A4, dated November 01, 2016, indicated "When OEM [Original Equipment Manufacturer] guidelines are unavailable or not provided, we follow risk assessment scoring"</p> <p>6. In interview, on 11-01-2016 at 12:35 pm, employee #A4 indicated a State waiver was unavailable and no other 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.</p> <p>Based on document review and interview, the facility failed to document a schedule for preventive maintenance (PM) of 2 of 14 pieces of equipment.</p>	S 1162	Deficiency Correction: UHS was contacted and requested to perform PM on the 2 pieces of equipment identified in the SOD using manufactures guidelines. Deficiency Prevention: The	03/10/2017

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S 1166 Bldg. 00	<p>Findings include:</p> <p>1. Review of documents indicated there was no preventive maintenance schedule for a portable x-ray machine and a dishwasher located in the occupational therapy area.</p> <p>2. In interview on 11-02-2016 at 10:50 am, employee #A4, Director Plant Operations, confirmed the above and no documentation was provided prior to exit.</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>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.</p> <p>Based on document review and interview, the hospital failed to document a current leakage check on 6 of 14 pieces of equipment.</p>			S 1166	<p>equipment listed in the SOD was placed on the UHS equipment detail to ensure schedule PM is performed using manufactures guidelines. If the manufactures guidelines are not available, a risk assessment will be performed by UHS. The risk assessment will be forwarded to the ISDH for review and waiver to utilize the risk assessment. The risk assessment and ISDH waiver will be filled onsite and available for regulatory purposes. Responsible Party: The Director of Plant Operations is responsible for ongoing compliance.</p> <p>Correction Date: 3/10/2017</p> <p>Deficiency Correction: UHS was contacted and requested to perform a leakage check on the 6 pieces of equipment identified in the SOD using manufactures guidelines.</p>		03/10/2017

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	<p>Findings include:</p> <ol style="list-style-type: none"> Review of documents indicated there was no documentation of current electrical leakage check for a portable x-ray machine, a dietary dishwasher, an electrocardiogram machine, the emergency code call system, a floor scrubber, and a dishwasher located in the occupational therapy area. In interview, on 11-02-2016 at 10:50 am, employee #A4, Director Plant Operations, confirmed there was no documentation of a current leakage check on the above-stated pieces of equipment. No other documentation was provided prior to exit. 		<p>Deficiency Prevention: The equipment listed in the SOD was placed on the UHS equipment detail to ensure schedule PM is performed using manufactures guidelines including leakage checks. If the manufactures guidelines are not available, a risk assessment will be performed by UHS. The risk assessment will be forwarded to the ISDH for review and waiver to utilize the risk assessment. The risk assessment and ISDH waiver will be filled onsite and available for regulatory purposes.</p> <p>Responsible Party: The Director of Plant Operations is responsible for ongoing compliance.</p> <p>Correction Date: 3/10/2017</p>		