STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150051	A. BUILDING 00 B. WING	07/28/2016

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INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSPITAL	601 W SECOND ST BLOOMINGTON, IN 47403

(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 0000 Bldg. 00	This visit was for a State licensure survey. Facility Number: 005047 Dates: 7/25/16 to 7/28/16 QA: 9/27/16 jlh	S 0000		
S 0178 Bldg. 00	410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a) (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. Based on observation and interview, the hospital failed to post a copy of the license at three (3) off-site locations (Off-sites 2, 3 and 4). Findings: 1. On 7/27/16 between 2:45pm - 3:30pm, during tour of off-site 2, in the presence of S1, Manager of Cardiac Ancillary Services, it was observed that no hospital license was posted.	S 0178	ISDH Tag: 0178 1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Current Hospital Licenses have been printed. Once**	10/31/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	2. On 7/27/16 at 3:30pm, S1 indicated the facility did not have a copy of the hospital licence posted. 3. On 7/28/16 between 9:45am, - 10:00am during tour of off-site 3, in the presence of S2, Lab Assistant, it was observed that no hospital license was posted. 4. On 7/28/16 at 10:00am, S2 indicated the facility did not have a copy of the hospital licence posted. 5. On 7/28/16 between 10:10a - 10:30am during tour of off-site 4, in the presence of S3, Program Director, it was observed that no hospital license was posted. 4. On 7/28/16 at 10:30am, S3 indicated the facility did not have a copy of the hospital licence posted.		**the frames are built, the licenses will be posted at all off sites.** 2.How are you going to prevent the deficiency from recurring in the future? **This item will be included in regulatory readiness rounds**. 3.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? (this just needs a title, not the person's name) **1.Marketing and Community Relations Graphic Designer** **2.Facilities Director** 1.By what date are you going to have the deficiency corrected? **October 31, 2016**	
S 0406 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and			

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	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: (1) All services, including services furnished by a contractor. Based on document review and interview, the quality assessment and performance improvement (QAPI) program failed to include 5 directly provided services (biomedical engineering, EEG (electroencephalography), EMG (electromyelography), pediatrics and therapeutic radiology) and 4 contracted services (biohazard waste hauler, blood bank, contracted lab services, contracted nursing) in its review and evaluations for the past 6 quarters. Findings: 1. Review of the document titled 2016 Quality and Safety Plan indicated the following: a. The Quality and Safety Program is...system-wide...assess process of care, services, and operations. b. The Quality and Safety Program applies to all (hospital) employees, volunteers, and contracted services. c. Involving all departments, their directors, and employees to participate in	S 0406	ISDH Tag: **0406** 1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **Updated Scorecards with measures for all listed areas will be presented to the Quality Improvement Committee (QIC) of the Board on November 2, 2016.** 2.How are you going to prevent the deficiency from recurring in the future? **These scorecards have been added to the checklist of required departments submitting quarterly scorecards. These department scorecards are also added to the agenda of the QIC in 2017.** 3.Who is going to be responsible for numbers 1	11/02/2016

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	the Program. d. Establishing reporting mechanisms, i.e. a department quality scorecard so that pertinent findings and recommendations from these activities are shared with key stakeholders. 2. Review of Board of Directors Quality Improvement Committee (QIC) Minutes dated 4/20/16 indicated the 2016 Quality & Safety plan was approved by the QIC. 3. Review of 4 quarters of 2015 and the first 2 quarters of 2016 QAPI meeting minutes and reports, lacked documentation of program review or evaluation of the following services: biomedical engineering, EEG, EMG, pediatrics, therapeutic radiology, contracted biohazard waste hauler, blood bank, contracted lab services and contracted nursing. 4. On 7/28/16 at 12:15pm, A5, Interim Quality Director, indicated the QAPI program/committees did not included review or evaluation for the services of biomedical engineering, EEG, EMG, pediatrics, therapeutic radiology, contracted biohazard waste hauler, blood bank, contracted lab services and contracted nursing in 2015 or to date in 2016.		and 2 above; i.e., director, supervisor, etc.? (this just needs a title, not the person's name) **Director - Diagnostic Imaging and Respiratory Care Services Hospital Safety Officer** **Director of Nursing** **Manager of Nursing Operations - Pediatrics** **Director of Laboratory Services** 4.By what date are you going to have the deficiency corrected? **November 2, 2016**	

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	5. On 8/10/16 at 10:42am, A5 indicated the 2016 Quality and Safety Plan is to be final approved by the Governing Board at their 8/2016 meeting.			
S 0754 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. Based on document review and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedures for two of twenty blood units. Finding(s) included: 1. The policy, "Blood Administration Profile", Policy: NURS-B-160,	S 0754	Plan of Correction Questions ISDH Tag: 0754 1.How are you going to correct the deficiency? If	12/01/2016

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	Effective Date: 1/2014, read: "Verify there is a signed Blood Consent form on the patient's chart." 2. One patient received two blood units without benefit of a signed Blood Consent form including: --Units 11a & 11b, administered on 5/10/16 at 1:14 a.m. and on 5/10/16 at 1:40 a.m. respectively, were each administered without benefit of a signed Blood Consent form. 3. On 7/26/16 at 10:15 a.m., staff member #16, (nurse witness) acknowledged that the two above-listed patient blood units had been administered without a signed Blood Consent form.		already corrected, include the steps taken and the date of correction. **All inpatient nurses required to attend competencies which include a session on blood administration. Please refer to attachments for competency validation. Competency sessions began on 10/6/16 and will be completed by 12/1/16.** 2.How are you going to prevent the deficiency from recurring in the future. **All new hired nurses receive extensive education on our blood administration processes and all nurses receive annual blood administration competencies.** **Audit to determine all nurses completed competency will be following the 12/1/2016 deadline. Random sample**	

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			of blood transfusions will be reviewed for signed and completed consent. This review begins on transfusions completed beginning October 1 going forward. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? (this just needs a title, not the person's name) **Clinical Education and Practice is responsible for orientation content and competency validation.** 4.By what date are you going to have the deficiency corrected? **All competency sessions are scheduled to be completed by December 1, 2016.**	
S 0952 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous			

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	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 record review and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedures for three of twenty blood units. Finding(s) include: 1. The policy, "Blood Administration Profile", Policy: NURS-B-160, Effective Date: 1/2014, read: "Vital signs Documentation Transfusion started: Blood should be started within 25 minutes from the time it left the Blood Bank. 15-20 minute vital signs: Take vital signs 15--20 minutes after the start time..." 2. In review of documentation for three blood units, complete documentation, per policy, on the Transfusion Record form, was incomplete including: --Unit 1a, was administered on 7/18/16 at 3:06 p.m.: The unit's	S 0952	ISDH Tag: **ISDH S952 1-2** 1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. *Documentation times for the 15 minute vital signs differed from the policy statement. There was confusion between the IU Health System Lab blood policy and the IU Health Bloomington clinical blood policy. The Blood Review Committee met on Tuesday, September 13th and reviewed both policies. The policy at IU Health*	12/01/2016

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	15-20 minute vitals were documented at 3:19 p.m. (13 minutes, 2 minutes too early). --Unit 4b, was administered on 6/28/16 at 3:16 p.m.: The unit's 15-20 minute vitals were documented at 3:26 p.m. (10 minutes, 5 minutes too early). --Unit 8b, was administered on 5/30/16 at 4:32 p.m.: The unit was released from the blood bank at 4:03 p.m.; however, it wasn't started until 4:32 p.m. (29 minutes, 4 minutes too late past the 25 minute requirement for starting a unit). 3. On 7/26/16 at 10:15 a.m., staff member #16 (nurse witness) acknowledged that the three above-listed blood units had incorrect or incomplete documentation, per the blood administration policy.		*Bloomington has been updated to reflect the system lab policy regarding the timing of the 15 minute vital signs.* *In regards to the time a unit of blood was released from the blood bank to the time that it was started, there was also confusion between the IU Health System Lab blood policy and the IU Health Bloomington clinical blood policy. When the Blood Review Committee met on September 13th, and both policies were reviewed, this point was also corrected on the IU Health Bloomington clinical lab policy to reflect the system lab policy.* *The updated policy is in the approval process. It is planned to have final approvals by October 25th, 2016* 2.How are you going to prevent the deficiency from recurring in the future? *We are currently in the process of*	

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			updating/educating nursing staff on the blood administration process and requirements at our in-person annual Fall Competency/Education Days, which will be completed by December 1, 2016. Blood bank staff complete audits of transfusion record following transfusion completion to evaluate compliance with vital signs. This was a previous process that is being continued. 3.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? (this just needs a title, not the person's name) Clinical Nurse Specialist, Blood bank staff 4.By what date are you going to have the deficiency corrected? *December 1, 2016*	
S 1028 Bldg. 00	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E) (d) Written policies and procedures shall be developed and implemented that include the following:			

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	(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (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. Based on document review, observation and interview, the hospital pharmaceutical services failed to ensure for security of medications in one area (ambulance bay). Findings: 1. Review of Policy #: INTER-M-310 titled Medication Storage, indicated the following: a. Drugs will be stored under secure conditions throughout the distribution system protecting them from diversion. Medications outside the pharmacy will be stored in Automated dispensing cabinets, retrievable only by persons given proper, password-controlled access by pharmacy personnel. b. Approval Date: March 2014 2. Review of Policy #: 06.20 titled Medication Storage, indicated the following: a. Drugs will be stored under secure conditions throughout the distribution system protecting them from diversion.	S 1028	ISDH Tag: 1028 1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **The emergency department garage will have all doors secured by employee ID badge readers or key pads with controlled access.** **Securing all doors with controlled access will protect all ambulances and prevent public access.** 2.How are you going to prevent the deficiency from recurring in the future?	11/15/2016

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	Medications outside the pharmacy will be stored in AcuDose cabinets, retrievable only by persons given proper, password-controlled access by pharmacy personnel. b. Approval Date: June 2016 3. On 7/25/16 between 1:30pm and 3:00pm, during facility tour, in the presence of A5, Interim Quality Director, the following was observed: a. Upon approach of the open ambulance bay, from the pedestrian sidewalk area, an ambulance was observed parked in the bay, unsecured, with its rear doors open. The ambulance was accessible without a deterrent. b. Inside the ambulance (#3759) were medications on a shelf behind a clear glass-like, unlocked sliding door. Among the medications (not all inclusive) were the following: Sodium Bicarbonate 8.4% injectable and 7 Epinephrine 1:10,000 injectables. 4. On 7/25/16 at 1:50pm, S5, EMT (emergency medical technician) indicated the ambulance medications were not securely stored. 5. On 7/28/16 at 11:25am, S6, Director of Ambulance Services, indicated that for security purposes, ambulance bay doors should be lowered and the unloaded		**All ambulance arriving in the ED garage will be in a secured area while taking emergency patients into the ED and left unattended. Complete random weekly observation audits of ambulance garage doors to monitor compliance.** 3.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? (this just needs a title, not the person's name). **Maintenance supervisor for installation;** **Ambulance Supervisor for audit** 4.By what date are you going to have the deficiency corrected? **November 15, 2016.**	

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	ambulance closed when the ambulance is unattended.			
S 1197 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the hospital failed to maintain written evidence of regular inspection and approval by state or local fire control agencies. Findings: 1. Review of facility documents lacked evidence of regular fire control inspections by a state or local agency. 2. On 7/28/16 at 11:05am, A8, Administrative Coordinator of Clinical Engineering, indicated the fire marshal had not been to the facility for 3 years and documentation of the last inspection could not be produced.	S 1197	ISDH Tag: S1197 1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. **City of Bloomington Fire performed an inspection of the Hospital on 10/13/2016.** 2.How are you going to prevent the deficiency from recurring in the future?	10/13/2016

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			Created and scheduled an annual maintenance request to call for a Fire Marshall inspection in our CMMS program. 3.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? **The Hospital Safety Officer.** 4.By what date are you going to have the deficiency corrected? **10/13/2016**	
S 1906 Bldg. 00	410 IAC 15-1.6-6 REHABILITATION SERVICES 410 IAC 15-1.6-6(b) (b) The services shall be under the direction of a physician qualified by training or experience and supervised by a qualified person or persons.			
	Based on document review and interview, the hospital failed to ensure rehabilitation services were supervised by a qualified person(s) per their policy. Findings: 1. Review of the Job Description "Dir - Rehab Services-BTN, Job Code BTNM08, Date: November 30, 2015	S 1906	ISDH Tag: **S1906** 1.How are you going to correct the deficiency? If already corrected, include the steps taken and the	10/02/2016

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INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSPITAL	601 W SECOND ST BLOOMINGTON, IN 47403

(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
	indicated Qualifications to include "A State licensure for PT, OT, or SLP required. 2. Review of the personnel file of P8, Rehabilitation Director, lacked evidence of P8 having an Indiana license for PT, OT, or SLP. 3. On 7/25/16 at 11:00am, A19, Human Resources Consultant, indicated P8 did not hold an Indiana (State) PT, OT or SLT license.		date of correction. **Reviewed current job description and qualifications per policy; revised both to assure policy and job description/qualifications were in sync; notified involved individuals; Implemented necessary changes, effective October 2, 2016** 2.How are you going to prevent the deficiency from recurring in the future? **Ongoing policy and credentials review** 3.Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? (this just needs a title, not the person's name) **VP of Professional /Support Services and HR** 4.By what date are you going to have the deficiency corrected? **October 2, 2016**	