INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL

This visit was for State licensure survey of a hospital.

Dates of survey: 8/28/17 to 8/29/17

Facility number: 004683

QA: 10/18/2017

(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.

Based on document review, observation and interview the nurse executive failed to ensure staff follow the facility policy/procedure for isolation precautions related to personal protective equipment (PPE) and cleaning/disinfection of patient non-critical equipment for 1 of 6 (Medical Surgical Unit) areas toured.

Findings:

1. Policy/procedure, Standard and

Plan of Correction – S 554:

Findings:
Respiratory Staff (RT) witnessed not donning Personal Protective Equipment (PPE) correctly prior to entering an isolation room.

(1) How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction:

Education provided to all RT staff on the selection and utilization of PPE, including how to safely don and remove PPE in healthcare settings. A step-wise procedure for donning and removing PPE was demonstrated in the RT staff meeting for all Indiana University Health (IUH) Bedford RT staff with return demonstration by staff – completed 09.17.17

(2) How are you going to prevent the
Transmission Based Isolation Precautions, revised/reapproved on 11/16 indicated:

A. page 8: "Contact precautions: Use Contact precautions for patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient; and indirect contact with surfaces or items in the patient's environment...Before entering the patient room: Don isolation gown".

B. page 9: "When possible, dedicate the use of non-critical patient-care equipment to a single patient to avoid sharing between affected and non-affected patients. When sharing is unavoidable, such items shall be cleaned and disinfected before use for another patient".

2. While on tour of facility on 8/28/17 at approximately 1500 hours, accompanied by staff N1 (Manager Quality/Regulatory Risk) and N2 (Registered Nurse), staff N3 (Respiratory Therapist [RT]) was observed entering a patient's room on the medical-surgical unit labeled with a sign indicating "contact precautions" without donning a gown and was also observed placing a pulse oximeter in his/her pocket without cleaning/disinfecting after patient use.

<table>
<thead>
<tr>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission Based Isolation</td>
<td></td>
<td></td>
<td></td>
<td>deficiency from recurring in the future: Bi-monthly observations of RT staff for proper utilization of PPE will be completed for 3 consecutive months and results will be reported to Quality Council monthly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(3) Who is going to be responsible for numbers 1 and 2 above: Manager of Respiratory Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4) By what date are you going to have the deficiency corrected: 09.17.17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Findings: Witnessed RT staff placing a pulse oximeter in his/her pocket without cleaning/disinfecting after patient use</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1) How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(a) Standardize workflow established for the RT department on utilization of RT equipment in an isolation room including but not limited to placement of dedicated equipment in isolation patient rooms to be utilized on a single isolation patient to avoid sharing – Completed 09.18.17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(b) Mandatory infection prevention education to be completed by all RT staff related to maintaining a safe, healthful environment that minimizes infection exposure and risk to patients, healthcare workers, and visitors – Completed 11.03.17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(2) How are you going to prevent the deficiency from recurring in the future: Bi-monthly observations of dedicated RT equipment being utilized in isolation patient rooms will be completed for 3 consecutive months and the results will be reported to Quality Council monthly.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(3) Who is going to be responsible for numbers 1 and 2 above: Manager of Respiratory Services</td>
</tr>
</tbody>
</table>
3. Staff N1 was interviewed on 8/28/17 at approximately 1515 hours and confirmed the patient's room observed on the medical-surgical unit was labeled with a sign indicating staff were to observe isolation contact precautions prior to entering and leaving the patient's room. Staff N1 confirmed staff N3 did not properly don a gown prior to entering the patient's room and did not clean/disinfect the pulse oximeter after patient use. Staff N4 (Infection Preventionist) was interviewed on 8/29/17 at approximately 1330 hours and confirmed staff should follow policy/procedure for isolation precautions.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(4) By what date are you going to have the deficiency corrected: 11.03.17
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| S 0808   | 0808   | Bldg. | 410 IAC 15-1.5-5 MEDICAL STAFF             | S 0808   | 0808   | Bldg. | 410 IAC 15-1.5-5 (a)(2) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the governing board for the quality of medical care provided to patients. The medical staff shall be composed of two (2) or more physicians and other practitioners as appointed by the governing board and do the following: (2) Examine credentials of candidates for appointment and reappointment to the medical staff by using sources in accordance with hospital policy and applicable state and federal law. Based on document review and interview, the medical staff (MS) failed to examine credentials of 1 of 1 (MD1) initial appointment applicant by using Plan of Correction – S 808: 10/10/2017

Findings:
Review

State Form Event ID: TN4511 Facility ID: 004683 If continuation sheet
### Summary Statement of Deficiencies

#### (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sources in accordance with hospital policy for Life Saving Certification Requirements in 1 facility.**

Findings include:

1. Review of Medical Staff Bylaws, last reviewed 6/6/17, indicated the following:
   - **V: Procedure for Appointment and Re-Appointment**
     - 5.1 B. The application will not be deemed complete until all information required is received.
     - 5.2 B. Prior to making...recommendation, the Medical Executive Committee (MEC) shall examine the evidence of...current clinical competence, qualifications and...of the Practitioner and shall determine...whether the Practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested...

2. Review of the MS policy titled Life Saving Certification Requirements, reviewed/revised 8/2016, indicated the following:
   - **I. Purpose: To establish standards for cardiopulmonary resuscitation certification maintenance...**
   - **II. Scope: This policy applies to all MS and Advanced Practice Providers.**

---

#### How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction:

- Providers who administer sedation will be credentialed with a 90 day time limited waiver pending his/her obtaining required lifesaving certification if they do not have it at the time of initial appointment – Completed 10.10.17

---

#### How are you going to prevent the deficiency from recurring in the future:

- Compliance will be monitored by the Medical Executive Committee (MEC) at 30 day intervals up and documented in the MEC minutes.

---

#### Who is going to be responsible for numbers 1 and 2 above:

- Medical Staff Credentialing
### STATEMENT OF DEFICIENCIES

#### AND PLAN OF CORRECTION

**Identification Number:** 151328

**Multiple Construction**
- **A. Building:** 00
- **B. Wing:** _______

**Date Survey Completed:** 08/29/2017

**Name of Provider or Supplier:**

**Indiana University Health Bedford Hospital**

**Street Address, City, State, Zip Code:**

**2900 W 16TH ST**
**BEDFORD, IN 47421**

#### ID

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>___________________________________________</td>
</tr>
<tr>
<td>TAG</td>
<td>___________________________________________</td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiencies**

**Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information**

#### Summary Statement of Deficiencies

- **III. Exceptions:** See noted exceptions...

- **IV. Definitions:**
  - **ACLS:** Advanced Cardiac Life Support.
  - **PALS:** Pediatric Advanced Life Support.

- **V. Policy Statements:**
  - **A.** Physicians... CPR (Cardiopulmonary Resuscitation) competence is not a requirement, unless resuscitation is specific to a privilege requested.
  - **B.** Physicians applying for and maintaining sedation privileges must comply with...Procedural Sedation and Analgesia.
  - **F. ACLS Required:**
    - 5. Any provider granted privileges in Procedural Sedation.
  - **G. ACLS & PALS Required:**
    - 1. Anesthesiology

- **Review of MS credential files** indicated **MD1**, Chief of Anesthesia, had initial appointment to the MS on 8/1/17 and was granted privileges in the area of anesthesia at that time. The file lacked documentation of ACLS certification.

- **4. On 8/29/17 at approximately 1:30pm,** A4, Administrative Assistant, indicated anesthesia MS are required to have ACLS certification prior to appointment to the MS, prior to being granted privileges and are to maintain certification at all times. A4 confirmed the credential file of MD1 lacked documentation of ACLS certification and

- **(4) By what date are you going to have the deficiency corrected:**
  - 10.10.17

---

*State Form Event ID: TN4511*  
*Facility ID: 004683*  
*If continuation sheet:*  
*Page 6 of 15*
## SUMMARY STATEMENT OF DEFICIENCIES

### S 1014

**PHARMACEUTICAL SERVICES**

**Bldg. 00**

(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.

Based on observation, document review and interview the director of pharmacy failed to follow policies and procedures for the appropriate control, labeling, storage and monitoring of drugs in one area (training room crash cart) of one facility.

Findings include:

1. Review of hospital policies indicated the following:

   A. The policy titled Medication Storage Guidelines, last reviewed 7/17, indicated the following: V. C.

   Medication Storage or Oversight. 1. Medications may be readily retrievable for use...in examination/procedure areas, surgical areas, or nursing areas only when that physician was privileged in the area of anesthesia.

   **Plan of Correction – S 1014:**

   **Findings:**

   Expired medications utilized for simulation and education were observed in an unsecured, unlocked emergency/crash cart in an unlocked, unsecured training room of the hospital.

   Insidethedrawers oftheemergency/crash cartweremultiplemedicationsindicat ed for prescription only. The packages were sealed/unopen with some, but not all medications marked with yellow label indicating "Not areal drug. For training purposes only".

   (1) How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction:

   (a) Expired Pharmaceutical Product and Patient Own Medication policy was revised to

---

**State Form**

Event ID: **TN4511**  
Facility ID: **004683**  
If continuation sheet **Page 7 of 15**
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE

2900 W 16TH ST
BEDFORD, IN 47421

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

1. Pharmacist is responsible for ensuring that employees understand their responsibilities under the control of authorized personnel.

2. On 8/28/17 between 1:15 pm and 3:00 pm, during facility tour, in the presence of A5, Plant Operations Manager, and S1, Education Coordinator, the following was observed inside an unlocked training room of the hospital: In the unlocked, open room was an unlocked, unsecured emergency/crash cart. Inside the drawers of the cart were multiple medications indicated for prescription use only. Observed items included, but was not limited to, the following:
   - 3 sealed/unopened boxes

   include verbiage specific to 'expired medication vessels (cartons/vials/boxes) that are beneficial for use in simulation and training may be shared once emptied by pharmacy staff according to EPA standards and safe handling practices. All medication must be removed prior to transfer to the intended IU Health education and training department' (A.1.d.) – Completed 09.08.17

   (b) Education Department specific Medication Vessel Sharing Policy for Education and Training Purposes and Medication Vessel Surrender Log was developed to provide guidelines to the Education Department staff for the transfer and receipt of empty medication vessels (cartons, vials, bags, containers, etc.) from the pharmacy to the education and training department of IU Health Bedford Hospital to benefit simulation and training related to safe medication administration practices. – Completed 09.08.17

   (2) How are you going to prevent the deficiency from recurring in the future: An audit of the Education Department simulation crash cart for compliance of policies and logs will be completed monthly for 3 consecutive months by the Education Coordinator and results will be reported to Quality Council monthly.
Lidocaine 2% 100 mg/5ml with a yellow sticker type label which indicated "Not a real drug. For training purposes only.
* 1 sealed/unopened box
Naloxone HCL 1mg/ml, Leur-jet. Expiration date 3/12
* 2 opened 8.4% Sodium Bicarbonate injectables 50mEq. No add-on label was noted. Expiration 1/Dec/2012.
  * 7 Epinephrine 1:100 injectables
  * 2 Atropine Sulfate 0.1mg/ml. Expiration 1, May 2017
* 1 250ml bag Dopamine HCL 800mcg/ml, in sealed outer package
* 1 100ml bag Magnesium Sulfate 10mg/ml, in sealed outer package

3. On 8/28/17 between 1:15pm and 3:30pm, S1 indicated that the medications in the crash cart were not actual medications and that the pharmacy replaces medications with non-medication solutions and returns them to the packaging for simulated use in training. S1 verified that most of the boxes and packaging appeared sealed and that all items in the cart were past the expiration dates noted. S1 agreed to provide documentation of pharmacy destruction of medications in the crash cart. S1 later indicated that after a discussion with the pharmacist, it was determined that the hospital did not have...
### Statement of Deficiencies and Plan of Correction

#### Identification Number:
- X1) PROVIDER/SUPPLIER/CLIA
- 151328

#### Multiple Construction

<table>
<thead>
<tr>
<th>A. Building</th>
<th>B. Wing</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td></td>
</tr>
</tbody>
</table>

#### Date Survey Completed
- 08/29/2017

#### Name of Provider or Supplier
- INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL

#### Street Address, City, State, Zip Code
- 2900 W 16TH ST
- BEDFORD, IN 47421

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Regulatory or LSC Identifying Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1162</td>
<td>410 IAC 15-1.5-8</td>
<td>PHYSICAL PLANT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>410 IAC 15-1.5-8(d)(2)(A)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Documentation of the observed medication containers having been replaced with non-medication solutions.

S1 also indicated the hospital did not have documentation of monitoring the training cart contents and that the contents of the packages/syringes should have been destroyed and should not have been in an accessible area or unlocked cart.

#### Findings:

On August 28, 2017, upon review of the defibrillator in the Cardiopulmonary Department, it was noted documents titled DefibrillatorCheckList lacked documentation of completion of any daily or monthly maintenance tasks for any day(s) in the month of June, July, or August.

- **Plan of Correction – S 1162**
- **Completion Date**: 08/29/2017

#### Cross-Referenced to the Appropriate

- **410 IAC 15-1.5-8**
- **(d)** The equipment requirements are as follows:
- **(2)** There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:
- **(A)** All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.

Based on observation, document review and interview the hospital failed to ensure 1 piece of equipment (defibrillator) in 1 area (cardiac rehab) was on a documented maintenance schedule in accordance with hospital procedure or manufacturer recommendations.
Findings include:

1. On 8/28/17 between 1:15 pm and 3:00 pm, during facility tour, in the presence of A5, Plant Operations Manager, and S2, Registered Nurse, in the cardiac rehab unit, a defibrillator was observed atop the emergency/crash cart.

2. Review of the manufacturer's manual for the Lifepak 12 defibrillator indicated the maintenance schedule to include daily, monthly, semi-annual and annual maintenance tasks.

3. Review of the hospital procedure documents for Daily and Monthly testing of defibrillators titled Procedure for Required Daily Lifepak Testing, Pacing Mode Monthly Check and Procedure for Required Monthly Lifepak Testing, unable to determine date of implementation or review, indicated the following:
   - Procedure for Required Daily Testing: 4 tasks were listed.
   - Procedure for Required Monthly Testing: 18 steps were listed in the Procedure.

4. Review of documents titled Defibrillator Check List lacked documentation of completion of any daily or monthly maintenance tasks for any day(s) in the months of June, July or August 2017.

(1) How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction:

The policy Medical Alert Cart (MAC) was reviewed with the registered nurses within the Cardiopulmonary Department and the process for documentation of daily defibrillator checks verbalized by the registered nurses – Completed 08.28.17

(2) How are you going to prevent the deficiency from recurring in the future:
5. On 8/28/17 at approximately 3:00pm
S2 verified that the Defivrillator Check
List lacked documentation of daily and/or
monthly tasks having been completed for
June, July or August 2017.

A daily audit of the Lifepak
defibrillator testing and
documentation will be completed
for 3 consecutive months to ensure
compliance and results will be
reported to Quality Council
monthly.

Who is going to be responsible
for numbers 1 and 2 above:
Manager-Cardiopulmonary/Intensiv
e Care Departments

By what date are
you going to have the
deficiency corrected:
08.28.17

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1164</td>
<td>410 IAC 15-1.5-8</td>
<td>PHYSICAL PLANT</td>
<td></td>
</tr>
<tr>
<td>Bldg. 00</td>
<td>410 IAC 15-1.5-8(d)(2)(B)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

(B) There shall be evidence of
preventive maintenance on all
equipment.
Based on document review, observation and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 13 pieces of equipment (2 walkers, 10 crutches and 1 wooden stair set) in one facility.

Findings include:


2. On 8/28/17 between 1:15 pm and 3:00 pm, during facility tour, in the presence of A5, Plant Operations Manager, in the physical therapy equipment storage room, the following was observed: In a stack of walkers were 2 walkers with tips on legs missing and the legs ends were covered in dirty appearing frayed tape. Hanging on a wall type pegboard were 10 crutches with rubber type arm and hand supports. Each area with rubber was noted to be hard and cracked. In the room was also a set of wooden stairs with rails.

3. Review of the manufacturers manual for the Carex Dual Release walker indicated that Maintenance should be
done at least every six months.

4. On 8/29/17 at approximately 2:30pm, A5, Plant Operations Manager, and A16, Biomedical, indicated the hospital did not have documentation of PM for the walkers, the crutches or the stair set.

Walkers found to have worn and/or cracked rubber tips and missing documentation of preventive maintenance completion.

(1) How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction:

Walkers found to have worn and/or cracked rubber tips were removed from service - Completed 08.28.17

(2) How are you going to prevent the deficiency from recurring in the future:

(a) Inventory of all walkers completed and documented – completed 10.27.17

(b) Safety Check/Preventative Maintenance (PM) will be completed bi-annually according to Manufacturer Instructions for Use (MIFU) and reported to Quality Council bi-annually – Completed 11.01.17

(3) Who is going to be responsible for numbers 1 and 2 above:

Manager of Rehab Services

(4) By what date are you going to have the deficiency corrected:

11.01.17
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**Identification Number:** 151328

**Date Survey Completed:** 08/29/2017

**Name of Provider or Supplier:**

**Street Address, City, State, Zip Code:**

Indiana University Health Bedford Hospital

2900 W 16TH ST

Bedford, IN 47421

### SUMMARY STATEMENT OF DEFICIENCIES

**Findings:**

On August 28, 2017 it was noted that 1 wooden stair set was missing documentation of preventive maintenance completion. Note: Post-survey wooden stair set were noted to have preventative maintenance (PM) completed in February 2017

(1) **How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction:**

The wooden stair set added to the Clinical Engineering PM schedule. PM completed according to the MIFU – Completed 11.06.17

(2) **How are you going to prevent the deficiency from recurring in the future:**

PM will be completed and documented according to MIFU and reported to Quality Council annually.

(3) **Who is going to be responsible for numbers 1 and 2 above:**

Facilities Manager

(4) **By what date are you going to have the deficiency corrected:**

11.06.2017