Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005089	A. BUILDING: ______ B. WING ______	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S MEDICAL CENTER	**3700 WASHINGTON AVE EVANSVILLE, IN 47750**

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S 000	INITIAL COMMENTS This visit was for a State licensure hospital survey. Dates of survey: 8/10/15 to 8/13/15 Facility number: 005089 QA: cjl 09/09/15 IDR Committee met on 10-19-15: Tag S1226 deleted. JL	S 000		
S 308	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (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: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. This RULE is not met as evidenced by: Based on document review and interview, the governing board failed to provide evidence of department/job specific orientation for 2 of 4 director files reviewed (staff members #AA3 and AA7). Findings include:	S 308		9/23/15

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S 308	Continued From page 1 1. Staff member #AA3 (Director of Facilities) was hired 10/1/12. His/her personnel file lacked department/job specific orientation. 2. Staff member #AA7 (Director of Health Information) was hired 10/8/07. His/her personnel file lacked department/job specific orientation. 2. Staff member #A19 (Human Resources Manager) verified the above at 12:50 p.m. on 8/13/15.	S 308		
S 312	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(D) (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: (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. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to complete annual performance evaluations for 2 of 2 agency nurses (staff	S 312		9/23/15

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S 312	Continued From page 2 members #N1 and N2). Findings include: 1. Staff member #N1 (agency Registered Nurse) began employment at the facility on 8/16/13. His/her personnel file lacked evidence of a performance evaluation. 2. Staff member #N2 (agency Registered Nurse) began employment at the facility on 11/5/13. His/her personnel file contained an evaluation from the staffing agency dated 7/6/15, however lacked any input from the facility. 3. Staff member #A19 (Human Resources Manager) verified the above in interview beginning at 12:15 p.m. on 8/13/15 and indicated that the facility had no input on the performance evaluation for staff member #N2. 4. Staff member #A1 (Accreditation Manager) indicated in interview at 1:50 p.m. on 8/13/15 that the facility has no policy for evaluations but the practice is to do them annually.	S 312		
S 406	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 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	S 406		9/25/15

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S 406	Continued From page 3	S 406		

following:

(1) All services, including services furnished by a contractor.

This RULE is not met as evidenced by:
Based on document review and interview, the hospital failed to ensure 4 off-site areas of the hospital participated in the quality assessment and performance improvement (QAPI) program (Surgicare Crosspoint, Center for Advanced Medicine, Westside Radiology and Northbrook) and failed to ensure 11 directly provided services were included in evaluation (Electromyelography (EMG), Lithotripsy, Infusion therapy, In-patient Magnetic Resonance Imaging (MRI), Neurosurgical services, Positron Emission Tomography (PET) scans, Peripherally Inserted Central Catheter (PICC) services, Psychology, Diagnostic Radiology, Reconstructive Surgery and Renal Dialysis) and 2 contracted services (Biohazardous Waste Hauler and Blood Bank).

Findings:

1. Review of the document titled Performance Improvement and Patient Safety Plan Fiscal Year 2015, indicated in Appendix A: The purpose...is to provide: 1. an oversight council for direction and guidance for quality and patient safety initiatives across the hospital. The plan was approved 8/29/14.

2. Review QAPI meeting minutes and reports from fiscal year (FY) 2015 lacked evidence of quality reporting from the following off-sites: Surgicare Crosspoint, Center for Advanced Medicine, Westside Radiology and Northbrook.

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S 406	Continued From page 4	S 406		

The documents also lacked evidence of QAPI evaluation/review of the following services: Electromyelography (EMG), Lithotripsy, Infusion therapy, In-patient Magnetic Resonance Imaging (MRI), Neurosurgical services, Positron Emission Tomography (PET) scans, Peripherally Inserted Central Catheter (PICC) services, Psychology, Diagnostic Radiology, Reconstructive Surgery and Renal Dialysis.

3. On 8/12/15 at 11:45am, A8, Executive Director of Quality, indicated the 4 off-sites: Surgicare Crosspoint, Center for Advanced Medicine, Westside Radiology and Northbrook, had not reported quality activity to the QAPI committee/program. A8 also indicated the 11 directly provided services (Electromyelography (EMG), Lithotripsy, Infusion therapy, In-patient Magnetic Resonance Imaging (MRI), Neurosurgical services, Positron Emission Tomography (PET) scans, Peripherally Inserted Central Catheter (PICC) services, Psychology, Diagnostic Radiology, Reconstructive Surgery and Renal Dialysis) and the 2 contracted services (Biohazardous Waste Hauler and Blood Bank) had not been included in QAPI reviews for FY 2015.

S 554	410 IAC 15-1.5-2 INFECTION CONTROL	S 554		9/18/15

410 IAC 15-1.5-2(a)

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

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S 554	Continued From page 5	S 554		

This RULE is not met as evidenced by:
Based on document review, observation and interview, the facility failed to follow its policies regarding infection control and housekeeping in seven (7) areas toured.

Findings:

1. Facility policy 1594380, Environmental Services, indicated all patient care and non-patient care areas shall be cleaned and/or disinfected, keeping in mind Standard Precautions and infection control procedures. This includes: D. Wipe tables, furniture, counters, cabinets and others. M. Dust mop floor.

2. On 8/10/2015 at 1230 hours, while on tour of the Center for Advanced Medicine, accompanied by staff member A9, Manager, Imaging Services, the following was noted:
  a. The soiled utility room had trash and dust on the floor.
  b. The crash cart had a dusty layer on top of it.
  c. The Computerized Tomography room had not been cleaned since the week of 8/2-8/8/2015, according to the cleaning log. The floor had trash on it and was soiled and dusty. The sink counter in the room had a sticky substance on it.

3. Staff member A9 concurred with these findings.

4. On 8/10/2015 at 1445 hours, while on tour of the Obstetrics unit, accompanied by staff member A2, Risk Manager, the following was noted:
  a. Trash and dust on the floor of the linen storage room.
  b. The top of the crash cart had a layer of dust

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S 554	Continued From page 6 on it. 5. Staff member A2 concurred with these findings. 6. A. Hospital Policy 1448128 indicated G. Hand hygiene must be performed: 1. Before any patient care is given. 4. Before putting on gloves and after removal of gloves. 7. Before and after any invasive procedures such as administering injections. 7. On 8/11/2015 at 0900 hours, while on tour of offsite surgery center at Crosspoint, accompanied by staff member A1, Accreditation Manager, it was noted that nursing staff C1 in Bay 5 did not do hand hygiene before and after patient N26 contact, while getting patient ready for a surgical procedure. The same RN was noted to drop an ink pen on floor while wearing gloves, picked it up and then started patient IV (intravenous) line, without hand hygiene or changing gloves. Staff member A1 concurred with these findings. 8. On 8/11/15 at 0930, while on tour of the Emergency Department, accompanied by staff member C2, ED Manager, the following was observed: a. The tops of the adult and pediatric crash carts had a layer of dust on them. b. The patient refrigerator had brownish spilled substance on two shelves in it. c. The patient microwave oven had brownish substances on the interior walls and glass turntable. 9. Staff member C2 concurred with these findings. 10. On 8/12/2015 at 1130 hours, while touring	S 554		

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S 554	Continued From page 7	S 554		

the inpatient therapy department, hydrotherapy room, accompanied by staff member A2, Risk Manager, it was noted that the plastic covering the patient table and pillow both had tears in the plastic covering, making adequate cleaning of the surfaces between patients impossible.

11. Staff member A2 concurred with these findings.

12. Policy 1594380, Environmental Services, General Room Cleaning indicated that restrooms should be cleaned completely per restroom cleaning policy, as part of patient room cleaning.

13. On 8/12/2015 at 1300, while on tour of the eight patient rooms of the Sleep Center, accompanied by staff member A2, it was noted that cleaned patient room #2's bathroom smelled foul and the toilet had yellowish liquid on the back of it. The toilet interior also appeared soiled with brownish substance.

14. Staff member A2 concurred with these findings.

15. Sleep Center policy 1434871 indicated B. Positive Airway Pressure Equipment 2. Humidifier: after each use, wash in hot (140-160 degree), soapy water. Rinse well. Place humidifier chambers in Control III soak bucket for 10 minutes to disinfect. Rinse well. After soak is completed, rinse thoroughly with hot tap water and place on shelf in the sterile dryer to dry.

16. Patient rooms #2, 3, 6 and 7, which were cleaned after patient use had oxygen humidifiers which still contained fluid from the previous patient, and appeared not to have been cleaned and dried, per cleaning policy, risking cross

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S 554	Continued From page 8 contamination from one patient to another by the inhalation of dirty water. 17. Staff member A2 concurred with these findings. 18. Review of the P&P titled Infection Control indicated in G. Patient Care Equipment and Supplies, 1. Clean and contaminated supplies/equipment are stored separately. The P&P was approved 12/9/13. 19. On 8/12/15 during facility tour between 2:00pm and 4:00pm, in the presence of S6, Executive Director of Ambulatory Operations, and S7, Manager of Imaging, in a clean supply/equipment storage room of the radiology department the following was observed: shelves with sterile packaged patient supplies and a cart with a microscope on top. 20. On 8/12/15 at 2:30pm, S7 indicated the microscope on the "cytology" cart was used in that room for tissue observation of computed tomography (CT) samples brought in from the adjacent procedure room. 21. A6 and A7 indicated the process did allow for contaminated material to be brought in with clean supplies.	S 554		
S 804	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(a)(1) (a) The hospital shall have an organized medical staff that operates under bylaws approved by the governing board and is responsible to the	S 804		10/30/15

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S 804	Continued From page 9	S 804		

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:

(1) Conduct outcome oriented performance evaluations of its members at least biennially.

This RULE is not met as evidenced by:
Based on document review and interview, the medical staff (MS) failed to conduct outcome oriented performance evaluations for 4 of 4 reappointed allied health (AH) MS members (AH#2, AH#3, AH#4 and AH#5) at least biennially.

Findings:

1. Review of 4 reappointed AH MS (AH#2, AH#3, AH#4 and AH#5) credential files lacked evidence of performance evaluations.

2. On 8/11/15 at 10:15am, A11, Primary Source Coordinator, indicated performance evaluations were not kept in the credential files and would need to be obtained from A7, Vice President (VP) of Medical Affairs, or A8, Executive Director of Quality.

3. On 8/13/15 at 12:15pm, A8 indicated he/she did not pull the data for performance evaluations of AH MS members.

4. On 8/13/15 at 12:30pm, A7 indicated performance evaluations were not documented

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S 804	Continued From page 10 for AH MS members.	S 804		
S 912	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (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: (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.	S 912		9/25/15

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S 912	Continued From page 11	S 912		

This RULE is not met as evidenced by:
Based on document review and interview, the nurse executive failed to ensure physician orders were followed for 4 of 6 open patient records reviewed (patients #11, 12, 13 and 26).

Findings include:

1. Review of patient #11 medical record indicated the following:
(A) He/she was admitted to the 6 East Oncology Unit on 8/6/15.
(B) An order was written at 1904 hours on 8/6/15 to weigh the patient daily at 0600 hours.
(C) The record lacked evidence that the patient was weighed on 8/10/15 or 8/11/15 per order.

2. Staff member #18 (RN, registered nurse) verified the above at 11:00 a.m. on 8/11/15.

3. Review of patient #12 medical record indicated the following:
(A) He/she was admitted to the 5 South Medical/Surgical unit on 8/4/15.
(B) An order was written on 8/9/15 at 12:04 p.m. for midline incision dressing change with Nugauze three times a day.
(C) The record lacked evidence that the dressing was changed at all on 8/10/15.

4. Staff member #17 (RN) verified the above in interview at 11:30 a.m. on 8/11/15 and indicated that he/she did not use the Nugauze on the dressing change that he/she had completed on 8/11/15.

5. Review of patient #13 medical record indicated the following:
(A) The patient was admitted to the Medical

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S 912	Continued From page 12 Intensive Care Unit on 8/9/15. (B) An order was written on 8/9/15 at 0637 hours to report a heart rate above 120 or systolic blood pressure of less than 90. The patient's heart rate was 125 at 1330 hours on 8/10/15, 122 at 1430 hours on 8/10/15, and 123 at 1900 hours on 8/10/15. The patient's blood pressure was 88/44 at 0614 hours on 8/10/15, 82/36 at 1100 on 8/10/15, and 85/68 at 12:00 p.m. on 8/10/15. (C) The medical record lacked documentation that the physician was notified of the vitals per order. 6. Staff member #22 (RN) verified the above at 12:00 p.m. on 8/11/15. 7. Review of patient #26 medical record indicated the following: (A) An order was written at 8/5/15 at 0329 hours for vital signs three times a day. (B) The record indicated that vitals were taken only once on 8/6/15 and taken twice on 8/8/15. 9. Staff member #40 (RN) verified the above at 11:00 a.m. on 8/12/15.	S 912		
S 952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (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	S 952		10/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 952		S 952		

Continued From page 13

in accordance with subsection (b)(6).

This RULE is not met as evidenced by:
Based on document review and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for seven of twenty patients.

Finding include:

1. The policy, "Blood and Blood Components Administration, Guidelines and Table", approved 7/08/14, read:
"Physician and RN, 2 RNs or RN and LPN must document the following, prior to spiking the unit of blood, except in emergent cases.
Physician's order for administration. (need Order for Type and Cross and Give).
Transfuse start: document start date and time. repeat vital signs at 15 minutes from start time of transfusion.
When blood or components infused: Repeat vital signs and complete transfusion form (time completed and unfavorable reaction, yes or no)."

2. In review of seven patients receiving fourteen blood units, ten of these received-units did not have complete documentation, per policy, on the Blood Transfusion Record form:

Patient #1
--Unit #3a administered on 8/05/15 at 12:30 a.m. and unit #3b administered on 8/05/15 at 1:20 a.m: Both units were administered without benefit of an order.

Patient #3
--Unit #3a administered on 8/08/15 at 12:50 a.m.:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S MEDICAL CENTER	**3700 WASHINGTON AVE EVANSVILLE, IN 47750**

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S 952	Continued From page 14	S 952		

The 15 minute vitals were documented at 13 minutes
--Unit #3b administered on 8/08/15 at 04:36 a.m.: There was no documented 'end time' for this unit

Patient #5
--Unit #3a administered on 8/07/15 at 2:40 p.m.: The 15 minute vitals were documented at 20 minutes; there was no documented 'end time' for this unit

Patient #6
--Unit #3a administered on 8//15 at (not available): There was no 'start time' documented; the 15 minute vitals were not documented; there was no documented 'end time' for this unit

Patient #7
--Unit #3a administered on 8/03/15 at 10:47 p.m.: The unit was documented to have started at 10:47 p.m. in lieu of the correct time of 8:47 p.m.
--Unit #3b administered on 8/04/15 at 1:39 2:40 p.m.: There was no documented 'end time' for this unit

Patient #14
--Unit #3b administered on 8/03/15 at 5:23 p.m.: There was no documented 'end time' for this unit

Patient #20
--Unit #3b administered on 8/06/15 at 1:24 p.m.: There was no documented 'end time' for this unit

3. On 8/11/15 at 2:00 p.m., staff member #A14 acknowledged that the above-listed patients had received blood without benefit of complete documentation, per policy, as required.

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S1024	Continued From page 15	S1024		
S1024	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (C) Detection and quarantine of outdated or otherwise unusable drugs and biologicals from general inventory pursuant to their return to the manufacturer, distributor, or destruction. This RULE is not met as evidenced by: Based on document review, observation, and staff interview, the facility failed to ensure medications were stored in a secure manner for 1 of 8 units and failed to ensure outdated/unusable medications were removed from patient stock and returned to pharmacy per policy for 4 of 8 units toured. Findings include: 1. Facility policy titled "Medication Security" last reviewed/revised 8/20/14 states under policy statement: "All medications, prescription and non-prescription, stored in the pharmacy and throughout the hospital and off-campus locations will be stored in a secure manner."	S1024		9/25/15

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S1024	Continued From page 16 2. Facility policy titled "Medication Storage Area Inspection (Occupational and Convenient Care)" last reviewed/revised 4/12/13 states on page 2 of 3: "9. Outdated or otherwise unusable drugs will be identified and returned to the Pharmacy for proper disposition." 3. Facility policy titled "Medication Storage" last reviewed/revised 9/29/14 states on page 2 of 3: "4. Nursing Units a. All patient specific medications kept on the nursing units are stored in locking medication carts or cabinets. b. All non-patient specific medications (floorstock items) are kept in Pyxis Medstations." 4. During tour of the Medical Intensive Care Unit beginning at 11:45 a.m. on 8/11/15, three (3) vials of Intravenous Protonix were observed unsecured on top of the Pyxis unit. 5. Staff member #N01 (Department Manager) indicated the Protonix was to be returned to pharmacy. 6. During tour of the Rehab Unit beginning at 10:00 a.m. on 8/12/15, two (2) expired 1000 ml bags of Lactated Ringers with 5% Dextrose were observed in the storage room. Both expired on 5/1/15. Also there were 2 expired 1000 ml bags of Lactated Ringers with an expiration date of 8/1/15. 7. During tour of the Surgery Department beginning at 11:55 a.m. on 8/12/15, 2 of 2 crash carts contained expired medications. Expired items found in one (1) crashcart included 50% Dextrose with an expiration date of 8/1/15, Aminophylline with an expiration date of 8/1/15, and 2 vials of Heparin with an expiration date of	S1024		

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S1024	Continued From page 17 7/15/15. The second crash cart contained 2 vials of Aminophyline with an expiration date of 8/1/15. According to the crashcart checklists, the crashcarts had been checked for outdates on 8/5/15. 8. During tour of the facility offsite Urgent Care beginning at 9:45 a.m. on 8/13/15, 1 tube of Gentamicin ophthalmic ointment with an expiration date of 2/10/15 was located in procedure room 2. At the time of observation, staff member #N02 (Charge Nurse) threw the expired tube of ointment in the regular patient trash within the procedure room.	S1024		
S1118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (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: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. This RULE is not met as evidenced by: Based on observation and interview, the hospital created a condition that may result in a hazard by not securing 3 medical gas cylinders/tanks in the medical gas storage area. Findings:	S1118		9/16/15

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S1118	Continued From page 18 1. On 8/11/15 between 1pm and 4pm, during tour of the physical plant, in the medical gas storage room, the following was observed: 2 large unsecured cylinder type tanks labeled as oxygen and 1 unsecured medium sized tank tabled as carbon dioxide. 2. On 8/11/15 at 2:15pm, S2, Facility Manager, indicated all gas storage tanks should be secured from tipping by use of chains or a storage cart. A policy for storage was requested at that time. Documentation was not received prior to exit.	S1118		
S1124	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A) (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: (5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows: (A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.	S1124		9/23/15

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S1124	Continued From page 19 This RULE is not met as evidenced by: Based on document review, observation and interview, the facility failed to maintain patient equipment to ensure its operational safety. Findings: 1. Biomedical policy 1590648 indicated it is the facility's mission to provide a safe and clinically excellent environment for all Associates and those we serve each day. 2. On 8/12/2015 at 1230 hours, accompanied by staff member A2, risk manager, while touring the inpatient physical and occupational "joint care" unit, the following was noted: a. The wooden steps used for patient strengthening lacked an asset or other tag. Staff member #C3 indicated that staff tighten its screws when it gets loose, but there is no scheduled preventative maintenance. b. The stove and oven used in the occupational therapy area lacked asset tags and evidence of preventative maintenance. 3. Staff member A2 concurred with these findings.	S1124		