

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/11/2012
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NAME OF PROVIDER OR SUPPLIER  KOSCIUSKO COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 7/9/2012 through 7/11/2012</p> <p>Facility Number: 005113</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 07/26/12</p>	S0000		
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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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S0102	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on document review, medical records reviewed and staff interview, the facility failed to ensure the anesthesia duties were in accordance with scope of practice related to patient orders for 3 of 3 records reviewed.</p> <p>Findings include:</p> <p>1. IC 25-23-1 defines the scope of practice for nurses and IC 25-23-1-1.4 defines " Certified registered nurse anesthetist " (CRNA) scope of practice based on their education. Indiana Professional Licensing Agency memorandum dated 12/28/2011 states, "Certified Registered Nurse Anesthetists are not eligible for prescriptive authority. CRNAs may administer anesthesia without this</p>	S0102	<p>1. A letter was sent to CRNAs to explain that they do not have prescriptive authority in the state of Indiana and cannot order medications post-operatively for pain or nausea.</p> <p>2. A memo was sent from the Surgery/ Anesthesia Committee to all physicians to educate surgeons about their responsibility for oversight of post-operative medication orders.</p> <p>3. Modified forms N8171 and N8172 to remove CRNA as a signature option and make these forms a protocol.</p> <p>4. Post-operative anesthesia orders were made a protocol approved by Medical Staff at Surgery/Anesthesia Committee.</p> <p>5. Conduct monthly monitoring for the next six months for the presence of an order by the surgeon for implementation of protocol orders for all medication orders outside surgery. 100% of protocol implementations will have an order by the surgeon.</p> <p>6. The Director of Surgery will have oversight for these changes and quality monitoring.</p>	08/10/2012			

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	<p>authorization, as long as they meet the educational qualifications to do so."</p> <p>2. Patient #N7 medical record contained orders signed by the CRNA (staff member #12) including, but not limited to, Fentanyl for pain and Zofran for nausea.</p> <p>3. Patient #N8 medical record contained orders signed by the CRNA (staff member #13) including, but not limited to, Fentanyl for pain and Zofran for nausea.</p> <p>4. Patients #N9 medical record contained orders signed by the CRNA (staff member #13) including, but not limited to, Fentanyl for pain and Zofran for nausea.</p> <p>5. At 3:00 PM on 7/10/12, staff member #2 confirmed the CRNAs' written orders for prescriptive medications.</p>						

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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure Electroencephalography (EEG), Laundry/Linen and Pest Control services were part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <p>1. Quality Improvement Plan reviewed 2012 states, "All services that influence the care of inpatients and outpatients receiving services at Kosciusko Community Hospital shall be included in the purview of the Quality Improvement Program."</p>	S0406	<p>1. EEG Quality Assessment and Improvement.</p> <ul style="list-style-type: none"> <li>· Will monitor monthly turnaround times from test ordered till preformed and for time test completed till interpreted.</li> <li>a. Tests will be performed within 72 hours of the order 100% of the time.</li> <li>b. Tests results will be interpreted and available no more than 1 week from the time the test was completed.</li> <li>· Results of monthly monitoring will be reported to the Quality Team.</li> <li>· Quarterly Results will be reported to MEC on a quarterly basis.</li> <li>· Quarterly Results will be reported to the Board</li> <li>· The Sleep Lab Manager will be responsible for the monitoring and reporting of EEG</li> </ul>	08/08/2012

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	2. At 2:45 PM on 7/9/2012, staff member #3 indicated EEG, Laundry/Linen, and Pest Control services are not evaluated by the hospital's Performance Improvement Team.		<p>quality.</p> <p>1. Pest Control services</p> <ul style="list-style-type: none"> <li>· Contract developed with ACE Pest Control which includes the following monitoring.</li> <li>· The following monthly monitoring of Pest Control services will be done. <ul style="list-style-type: none"> <li>a. Company met monthly visit obligations 100% of the time as evidenced by log book</li> <li>b. Verbal debriefing provided to Housekeeping 100% of the time after service visits, as evidenced by housekeeping signature on the vendor's written report.</li> </ul> </li> <li>· Monitoring results of the Pest Control indicators will be presented to monthly to the Quality Team, quarterly to the Infection Control Committee, and twice a year to the Board of Trustees.</li> <li>· The Director of Environmental Services will be responsible for the monitoring and reporting of Pest Control Services.</li> </ul> <p>2. Linen/Laundry services</p> <ul style="list-style-type: none"> <li>· An addendum to the contract has been sent that included the following indicators that are monitored monthly. <ul style="list-style-type: none"> <li>a. Company met monthly facility linen needs for clean, undamaged linens 100% of the time as evidenced by the absence of customer complaints</li> <li>b. Linen carts are "clean" as evidenced by inspection of 30 linen carts per month</li> </ul> </li> </ul>		

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			<ul style="list-style-type: none"> <li>· Monitoring of the Linen/Laundry services to be completed monthly.</li> <li>· Monitoring results will be reported monthly to the Quality Team, quarterly to the Infection Control Committee and twice a year to the Board of Trustees.</li> <li>· The Director of Environmental Services will be responsible for the monitoring and reporting of Laundry Services indicator results.</li> </ul>		

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S0554	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, manufacturer's directions, policy and procedure review, and interview, the staff failed to ensure a safe, sanitary environment for patients by marking supplies to prevent outdated usage on 2 of 4 inpatient units and by ensuring the newborn nursery was clean.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>During the tour of the Intensive Care Unit at 10:00 AM on 07/10/12, accompanied by staff members #A2 and A16, 4 of 4 bottles of control solution for the glucometer were observed dated 8/11/12 with a discard date of 11/11/12. Manufacturer's directions were to discard the product 90 days after opening. Staff on the unit could not explain the dating since 8/11/12 was in the future.</li> <li>During the tour of the 3rd floor Surgical Unit at 11:00 AM on 07/10/12, accompanied by staff members #A2 and A4, 4 of 4 bottles of control solution for the glucometer were observed dated</li> </ol>	S0554	<p>Glucometer Controls</p> <ol style="list-style-type: none"> <li>PC Policy 600-28 was revised to require the expiration date for the control solution and the strips to be 90 days from opening. This is the more stringent manufacturer's expiration time frame and with requiring both the control solution and the test strips to expire 90 days from opening will make it easier for staff to remember.</li> <li>A card was placed in each glucometer supply case that gave instructions on the expiration date for both the control solution and the strips.</li> <li>Staff was educated by email notice on the change in the policy and the reminder cards in each box.</li> </ol> <p>The Department Directors of ICU, Med/Surg, ED, and OB are responsible for oversight of monitoring the solution and strips monthly for 3 months and report findings to the Quality Team. 100% compliance is expected. Cleanliness</p> <ol style="list-style-type: none"> <li>The wall area and suction canister was cleaned.</li> <li>The nursery wall area was added to the Housekeeper list of</li> </ol>	08/01/2012			

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	<p>8/24/12 with a discard date of 11/24/12. Manufacturer's directions were to discard the product 90 days after opening. Staff on the unit could not explain the dating since 8/24/12 was in the future.</p> <p>3. During the tour of the Newborn Nursery at 12:05 PM on 07/10/12, accompanied by staff members #A2 and A20, the wall ledges and suction canisters were observed with a heavy layer of dust.</p> <p>4. The facility policy "Accu-Chek Inform System, last revised 07/20/2010, indicated on page 9, "...11. ...Glucose control solutions are stable for three months after opening or until the expiration date, whichever comes first. The date the vial is opened should be written on the vial label."</p> <p>5. At 12:30 PM on 07/10/12, staff members #A2, A4, and A20 confirmed the control vials should be marked according to policy and housekeeping in the nursery needed to be improved.</p>		<p>places to clean in the nursery.</p> <p>3. The Suction canister was stored in a cabinet since it was only there for an emergency. It can still be easily obtained from the cabinet in an emergency. The Director of Obstetrical services will monitor the wall area for dust once a week for 3 months and report to the Manager of Housekeeping.</p>		

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S0748	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3).</p> <p>Based on medical record review, policy review, and interview, the facility failed to ensure all entries were authenticated and dated in 3 of 27 patient records reviewed (#N4, N12, and N26).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The medical record for patient #N4 indicated physician orders from 0250 on 04/09/12 that lacked authentication or notation by the nurse to indicate completion.</li> <li>The medical record for patient #N12 indicated a telephone restraint order from 0005 on 07/05/12 that lacked documentation of a physician signature, date, and time.</li> <li>The medical record for patient #N26 indicated physician's orders from 1720 on 05/21/12 and 1910 on 05/21/12 that lacked authentication or notation by the nurse to indicate completion.</li> </ol>	S0748	<p>Orders Not Signed off by RN</p> <ul style="list-style-type: none"> <li>Email sent to all nurses on Med/Surg, ICU and OB to educate them on the requirement to sign off physician orders.</li> <li>Monitoring of nurses signing off orders will be added as an indicator to the random medical record audit completed monthly for six months on Med/Surg, ICU and OB and will be reported through the Quality Team monthly.</li> </ul> <p>The Directors of Medical/Surgical, ICU and OB services will be responsible for monitoring and reporting. Restraint Orders</p> <ul style="list-style-type: none"> <li>Memo sent to physicians reminding them that restraint orders need to be signed, dated and timed the first time they see the patient.</li> <li>Hospitalist rounding nurses will be educated about the time frame for signing restraint orders at their next meeting and asked to assist in reminding their physicians of the signature time frame for restraints.</li> <li>100% of restraint medical records will be monitored monthly for the presence of Date, time and signature of physician within</li> </ul>	08/13/2012	

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	<p>4. The facility policy "Physician Orders", last revised 12/2011, indicated, "...Nursing personnel at [facility] note inpatient physician orders. ...VI. Transcription of orders: ...C. Orders are dated and timed when noted and signed off by a RN or LPN using their signature and title. D. Each order set must be signed off by an RN or LPN immediately after the order is transcribed or as soon as the nurse is notified of the new order."</p> <p>5. The facility policy "Restraint Use", last revised 12/2011, indicated, "...Telephone orders are acceptable, under established protocol for verbal orders but requires a face to face assessment by the physician within 24 hours at which time the physician must sign the order."</p> <p>6. At 12:20 PM on 07/11/12, staff members #A4, A16, and A20 confirmed the medical record findings.</p>		<p>24 hours of telephone order. The Director of Intensive Care will have oversight for the monitoring and reporting of this monitoring. Results will be reported through the Quality Team quarterly.</p>		

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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on medical record review, policy and procedure review, and interview, the registered nurse failed to ensure physician orders were followed for 1 of 1 male newborns (#N22) and failed to follow policy for 1 of 1 patients with critical lab values (#N2) and 1 of 3 transferred patients (#N13).</p> <p>Findings included:</p> <p>1. The medical record for the newborn male infant, #N22, indicated physician orders from 1820 on 04/24/12, "...14. Circumcision care as follows: A. Assess for bleeding every 30 minutes times 4, then every 4 hours times 5; then once per shift." The record indicated the circumcision was performed at 0840 on 04/26/12 and indicated documentation of checks at 0910, 0940, 1010, and 1035, but lacked any documentation of the 4 hour checks. The patient was discharged at 1930 on 04/26/12.</p> <p>2. The medical record for patient #N2</p>	S0930	<p>Critical Results</p> <p>1. Policy on Critical Results Notification changed to require results phone calls to be forwarded directly to the wireless phone of the nurse caring for the patient or if the nurse is busy, to the Charge Nurse. No one else is allowed to take the call.</p> <p>2. Staff educated on the policy change and the need to notify another physician if the physician does not return the call within 35 minutes.</p> <p>The Quality Officer will monitor critical results timely notification (within 35 minutes) to the physician and report it to the Quality Team, MEC and the Board. Transfer Records</p> <p>1. Staff were educated on the required transfer forms needed as well as transfers to the Bowen Center are the same as to another acute hospital and required the transfer forms to be included on the chart.</p> <p>2. 100% of transfers from inpatient units and ER will be monitored for the next three months for the presence of the required completed transfer</p>	08/10/2012			

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	<p>indicated 4 "Critical Tests/Critical Results" forms with critical Troponin results. The first form was from 0700 on 01/31/12 and indicated the physician was notified at 0720 on 01/31/12. The second form was from 1410 on 01/31/12, but lacked documentation of the physician notification or reason for no notification. The third form was from 0515 on 02/01/12 and indicated the physician was notified at 0530 on 02/01/12. The fourth form was from 0953 on 02/02/12, but lacked documentation of the physician notification or reason for no notification.</p> <p>3. The medical record for patient #N13 indicated a nurse's note from 0705 on 07/03/12, "Medics here to transport patient to Lutheran. Report to medics and called report to Lynn at CIC in Lutheran". The medical record lacked documentation of the required transfer forms.</p> <p>4. The facility policy "Notification of Critical Values", last revised 12/10 indicated on page 2 under Procedure, "...5. The nurse will review the value and immediately notify the attending physician. 6. The nurse will record the physician's name, the time the physician was notified on the form, and any new orders received in the patient's medical record. 7. If this value is critical but has improved from the last results, the nurse</p>		<p>forms.</p> <p>3. The Director of Emergency Department, Director of ICU, Director of Medical-Surgical and the Director of Obstetrics are responsible for the oversight of this education and monitoring. Circumcision Bleeding Checks . The Pre-printed order set (Form # N7024) was revised to be the same as what was included in the policy passed by the OB/Pediatric Committee. The requirement is to assess for bleeding every 30 minutes times 4. 2. Nursing staff educated regarding the form change.. 3. 100% of circumcision records will be audited for the next three months to ensure the bleeding checks are completed as ordered. Audit results will be presented monthly to the Quality Team. 4. The Director of Obstetrics is responsible for oversight of the staff education and monitoring.</p>		

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	<p>may determine not to notify the physician during late evening and night shift. They must then document the rationale for this decision in the Nurse's Notes."</p> <p>5. The facility policy "Discharge or Transfer of Patients to Other Facilities", last revised 4/11/11, indicated on page 2, "...3. The Transfer packet will be completed by nursing staff and the physician. The transfer packet will be sent with copies of pertinent medical record information with the patient to the receiving facility. 4. A verbal report will be called to the receiving facility by nursing staff."</p> <p>6. At 12:20 PM on 07/11/12, staff members #A4, A16, and A20 confirmed the lack of documentation regarding the circumcision checks, the notification or not of critical lab values, and the transfer documentation in the medical records.</p>			

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NAME OF PROVIDER OR SUPPLIER  KOSCIUSKO COMMUNITY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2101 E DUBOIS DR WARSAW, IN 46580			
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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <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).</p> <p>Based on document review, medical record review, and interview, the facility failed to ensure blood transfusions were administered according to facility policy for 4 of 5 patients who received blood transfusions (#N1, N2, N3, and N4).</p> <p>Findings included:</p> <p>1. The facility policy "Transfusion of Blood", last revised 04/15/11, indicated on page 3, "...2. Obtain patient's signature on the Consent for Transfusion Therapy Record. Health Care Representative/Power of Attorney or Legal Guardian may sign permits in the event of a confused patient or minors." Page 5 continued, "...d. A Laboratory technician and an RN or a competent LPN will review the blood requisition, match the patient's identification form to the unit of blood, visually inspect the unit of</p>	S0952	<p>Blood Forms Incomplete</p> <ol style="list-style-type: none"> <li>Staff educated on who can give consent over the phone for blood transfusions and that it needs to be documented.</li> <li>Staff also educated on the requirement for vital signs and documenting them on the blood form during a transfusion.</li> <li>Staff educated on the need for a second person to check and sign off on blood to be administered even in an emergency situation.</li> <li>100% of blood administrations will be monitored for the next six months by the Director of the Laboratory for compliance with consent, vital signs, and 2 signatures indicating checking for correct product to be administered to the correct patient.</li> <li>The monitoring results will be reported monthly to the Quality Team. The Directors of Lab, ED, Med/Surg, ICU, and Surgery will</li> </ol>	08/10/2012			

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	<p>blood, and sign appropriate forms for release of blood."</p> <p>On page 7 of the policy, it indicated, "...9. Two RNs or one (1) RN and one (1) competent LPN will complete a second check of the unit of blood at the patient's bedside. ...10. Perform pre-transfusion vital signs and assessment on patient and document on the Blood Bank Transfusion Record." Page 8 continued, "...b. RN remains at bedside and observes patient closely for 15 minutes for adverse transfusion reactions. c. Perform and document vital signs fifteen (15) minutes after the start of the transfusion. d. Reassess patient for signs of adverse reaction. Document assessment and vital signs on the form every hour (for adults) and every 30 minutes (infant/child) for the remainder of the infusion."</p> <p>2. The Blood Bank Requisition/Infusion Record from 01/05/12 for patient #N1 indicated a time and some vital signs scribbled/written over.</p> <p>3. The Blood Bank Requisition/Infusion Record from 01/30/12 for patient #N2 lacked documentation of a blood pressure with the 1 hour vital signs. A second form from 01/30/12 indicated only a temperature for the 1 hour vital signs and lacked documentation of 2 hour vital</p>		<p>be responsible for compliance with the blood administration policy. Corrections in Medical Record</p> <ol style="list-style-type: none"> <li>1. Staff education was conducted on how to make corrections in the medical record according to hospital policy 700-11 "Documentation in the Medical Record."</li> <li>2. The paper forms on 10 records per month per nursing department for the next six months will be monitored for 100% compliance with making corrections according to policy.</li> <li>3. The monitoring results will be reported monthly to the Quality Team.</li> <li>4. The Directors of ED, Med/Surg, ICU, Surgery, and OB will be responsible for the monitoring and reporting.</li> </ol>				

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	<p>signs although there were completed vital signs 17 minutes later at the completion of the unit.</p> <p>4. The Blood Bank Requisition/Infusion Record from 03/15/12 for patient #N3 indicated a date and time scribbled/written over. The Consent of Transfusion had the date scribble/written over and only had the signatures of 2 staff members (as required for a telephone consent), but lacked documentation of who gave the consent.</p> <p>5. The medical record for patient #N4 indicated an "Emergency Request for Uncrossmatched Blood" form from 04/09/12 for 2 units of uncrossmatched blood for emergency treatment signed by a nurse and initialed by a technician. The two Blood Bank Requisition/Infusion Records only had the laboratory documentation on them, but no vital signs or documentation of a second check prior to the administration of the blood.</p> <p>Nursing notes for patient #N4 indicated the first unit of blood was started at 0147 on 04/09/12, but lacked documentation that the blood was checked by 2 staff members prior to the administration. Vital signs were documented for 0147, 0202, 0217, and 0232. At 0247 on 04/09/12, the notation continued that the</p>						

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	<p>first unit of blood was completed and the second unit was started and vital signs were documented, but no indication that 2 staff members checked the second unit of blood before it was administered. The nursing notes lacked documentation of any other vital signs. The flowsheet from 04/09/12 indicated vital signs at 0349, 0449, and 0549 with a notation that the blood was completed at 0449.</p> <p>6. At 8:50 AM on 07/11/12, staff member #A4 indicated the Emergency Department manager indicated the computer was down at the time of the transfusions for patient #N4 which was why the forms were not completed and the documentation was in the nurse's notes.</p> <p>7. At 12:20 PM on 07/11/12, staff members #A4 and A16 confirmed the medical record findings.</p>				

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in three (3) instances: Laboratory, Main Janitorial Closet and Main Maintenance and Electrical Room.</p> <p>Findings included:</p> <p>1. Infection Control policy 200-04 last reviewed 10/2011 notes the hospital will adhere to OSHA as it relates to the safety of their staff.</p> <p>2. At 1:40 PM on 7/10/2012, the</p>	S1118	<p>Back Flow Preventer</p> <p>1. Plastic wrap was removed from the faucet and the back flow device was rebuilt. (Work Order #53064)</p> <p>2. This item will be added to the twice a year Safety Inspection check list to ensure the back flow devices are not tampered with and reported through the Safety Committee.</p> <p>The Director of Engineering will be responsible for ensuring this is monitored and reported. Eye Wash Station</p> <p>1. Installed an eye wash station at the sink in the housekeeping closet. (Work Order #53065)</p> <p>2. Housekeepers were educated at monthly meeting to only check batteries in this closet location due to proximity to the eye wash station.</p> <p>The Manager of Environmental Services will be responsible for ensuring batteries are only</p>	07/31/2012			

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	<p>laboratory was toured. The cleaning station for tubes and flasks was observed with a hose plastic wrapped around the faucet and the the umbrella of the atmospheric preventer and the hose was observed connected to a parts washer. The plastic wrap was preventing the back flow device from working properly if there was a back flush into the water line.</p> <p>3. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach</p>		<p>checked in the closet with the eye wash station by monthly observation for six months. Results of observations will be presented to the Safety Committee</p> <p>Protective Guards on Grinder</p> <ol style="list-style-type: none"> <li>1. Installed an eye wash station at the sink in the housekeeping closet. (Work Order #53065)</li> <li>2. Housekeepers were educated at monthly meeting to only check batteries in this closet location due to proximity to the eye wash station. The Manager of Environmental Services will be responsible for ensuring batteries are only checked in the closet with the eye wash station by monthly observation for six months. Results of observations will be presented to the Safety Committee</li> </ol>		

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	<p>but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>4. At 2:48 PM on 7/10/2012, the main janitorial closet was toured. A floor scrubber was present in the room charging the acid batteries. The room had a wall mounted eye washing kit with a 16-ounce bottle. The 16-ounce bottle of saline solution can only provide a 2-minute eye flushing in case of acid was splashed into a staff member's eyes.</p> <p>5. At 2:50 PM on 7/10/2012, staff member #5 indicated the housekeeping staff will check the water level of the batteries in the room.</p> <p>6. OSHA 29 CFRb1915.134 states, "Floor stand and bench mounted abrasive wheels used for external grinding shall be provided with safety guards (protection hoods). The maximum angular exposure of</p>			

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	<p>the grinding wheel periphery and sides shall be not more than 90 degrees, except that when work requires contact with the wheel below the horizontal plane of the spindle, the angular exposure shall not exceed 125 degrees. In either case the exposure shall begin not more than 65 degrees above the horizontal plane of the spindle. Safety guards shall be strong enough to withstand the effect of a bursting wheel."</p> <p>7. At 2:48 on 7/10/2012, the main maintenance electrical shop was toured. Two of two bench mounted grinding wheels were observed without protective shields covering at least one of the two grinding wheels. The rest was missing on one of the grinding wheels.</p>				

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