

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005038</p> <p>Survey Date: 5/19/14 to 5/21/14</p> <p>Surveyors:</p> <p>Trisha Goodwin, RN BSE Public Health Nurse Surveyor/Administrator</p> <p>Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>Ken Ziegler Medical Surveyor</p> <p>QA: claughlin 06/03/14</p> <p>On 09-02-14 IDR Committee deleted tag A1150.</p>	S000000		
S000406	<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</p>			

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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	<p>furnished by a contractor. Based on document review and interview, the hospital failed to include monitors and standards for 10 services directly-provided by the hospital, 1 service provided by a contractor and 1 arranged service as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility's QAPI program indicated it did not include monitors and standards specifically for the directly-provided service of the alcohol/drug program, biomedical engineering, dental services, electromyography, laundry, massage therapy, ophthalmic surgery, psychiatric emergency, forensic psychiatry, and geriatric psychiatry. 2. Review of the facility's QAPI program indicated it did not include monitors and standards specifically for the contracted service of biohazard waste hauling and the arranged services of ambulance service providers. 	S000406	<p>S 0406 On 06/06/2014, a meeting of Directors with responsibility for management of the 10 areas identified as non-compliant with the hospital's quality assessment and performance improvement program was held. At that time, the Director's identified either measures that would be initiated to correct this deficiency or clarified that measures were already being collected but were not being reported in such a way that the information was reaching the Board of Directors. In one instance, dental services, it was determined that the hospital no longer provided this service (no credentialed providers with privileges to perform this service). In another instance, forensic psychiatry, it was determined that while this service had been provided in the past it was no longer being provided and would not be provided in the future. Therefore, performance improvement measures will not be collected for these services. The following measures were identified as new performance improvement measures for direct services: Alcohol/drug program-chemical dependency discharges from the psychiatric inpatient unit that followed up with an initial outpatient chemical dependency appointment; Biomedical engineering-monitoring of equipment entering hospital</p>	06/21/2014			

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	3. In interview, on 5/22/14 at 2:00 pm, employee #A8 confirmed the above and no further documentation was provided prior to exit.		compared to equipment processed by Engineering Department; Massage therapy-staff compliance with hand washing between patients; and Psychiatric emergency-patient flow time (time to admit or transfer) through the emergency department. The following are direct service performance improvement measures that currently exist but either weren't being reported to the Board of Directors or were not separated out from aggregate data: Electromyography-EMG performed within 15 minutes of scheduled time and final EMG report completed within 2 days; Laundry-wash cycle temperature; Ophthalmic surgery-vitreotomy rate; and Geriatric psychiatry-fall rate. The following were identified as new performance improvement measures for contracted services: Ambulance service providers-scene times for ambulance runs; Biohazard waste hauling-final manifests of confirmation of destruction of materials within 30 days. The measures identified above will be reported to the Board of Governors by the Director of Organizational Excellence and Innovation in the annual Hospital-Wide Performance Improvement Plan. These measures will also be reported to the Hospital-Wide Performance Improvement Committee or Nursing Performance		

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S000726	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following:</p> <p>(A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based on observation and interview, the facility failed to ensure confidentiality of 15 total patient records in 2 instances.</p> <p>Findings:</p> <p>1. During facility tour on 5/20/14 at</p>	S000726	<p>Improvement Council or Medical Staff Office quarterly (or as appropriate). The Director of Organizational Excellence and Innovation will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>S 0726 The Radiation Oncology Department will become a secure area that can be accessed only by authorized staff and escorted patients/visitors by 7/11/14. The Department has 2 unsecured entrances: the first is a door that is used by staff who are bringing</p>	06/21/2014	

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	<p>11:20am in the presence of employees A5, S3 and S4 in a public accessible hallway of the radiation and oncology unit, 4 patient charts were observed unattended on a wall type charting stand. The top chart was open with patient information readily viewable.</p> <p>2. On 5/20/14 at 11:20am, in the presence of employees A5, S3 and S4, room R166 (nurse station) of the radiation and oncology unit was observed to be unattended with the sliding window and door both open. Eleven (11) patient records were noted to be out on the counter and patient information visible on the computer screen. No attending staff members were observed in the area during the time of observation.</p> <p>3. In interview on the above dates and times, employee S3 indicated the area was accessible by the public.</p>		<p>patients into the lab room to have blood drawn, or by staff who are bringing patients in to an assessment room to see the Palliative Care Nurse Practitioner. In the past, it has not been kept locked during business hours. The second unsecured site of entry is the primary entrance, a set of automatic doors that is accessed by pushing an electronic plate on the wall that can be opened by anyone. Effective 6/20/14, the first door will be locked at all times. A work order was issued on 6/13/14 to replace the electronic plate on the primary entrance with a badge reader that will permit entrance by authorized personnel only. The installation of this badge reader will be completed by 7/11/14. In the interim, the Director of Oncology Services and the Radiation Oncology Manager completed re-education of all Oncology staff on the proper protection of patient health information on 06/17/2014. Until the Radiation Oncology Department is made a secure area, patient charts are not to be left unattended in publicly accessible areas (e.g. wall type charting stand). Furthermore, when the nurse's station (where charts that are being worked on by the nurses are stored) is to be unattended, the window and door to this area is to be closed and locked. The Radiation Oncology Manager and the Oncology</p>		

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S000754	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(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.</p> <p>Based on review of the Blood Administration, Consent and Documentation transfusion policy, patient vital logs, and staff interview, the hospital failed to complete all documentation for evidence of informed consent using procedures and treatments</p>	S000754	<p>Director will monitor for compliance of proper protection of patient information periodically (minimum of twice daily by each). In addition, nursing and therapy staff will assist to remind physicians and monitor compliance. The Director of Oncology Services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>S0754 On 06/13/2014, the Blood Administration Performance Improvement Nurse (5th Floor Nurse Manager-responsible for monitoring the use of blood products throughout the hospital) provided re-education to all nurse managers regarding the requirement/policy and procedure to obtain a signed patient/guardian/POA consent document prior to the</p>	06/21/2014	

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	<p>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 for one (Patient #10) of ten patients receiving blood.</p> <p>Findings included:</p> <p>1. On 5/19/14 at 2:00 p.m., review of the policy, "Blood Administration, Consent and Documentation", Index: B02.01.03.04, Revised 2/14, read: "IMPLEMENTATION: Sequence, Intervention/Scientific Rationale: "Obtain patient's signature on Transfusion Consent Form"</p> <p>2. On 5/19/14 at 2:15 p.m., review of one patient receiving two blood units had a misdated consent form including:</p> <p>Patient #10: --The consent for both 1) Unit #1, administered on 5/06/14 at 1636</p>		<p>administration of blood products. As a part of the blood product pre-administration "checklist", a nurse not directly involved in the care of the patient must verify that an informed consent document has been signed by the patient/guardian/POA and is in place on the patient's chart. All nurse managers will in turn be responsible for providing re-education regarding this policy and procedure to their direct report nursing staff. Nursing staff education will begin on 06/16/2014 and will be completed by 06/21/2014. 10 charts involving blood product administration(s) will be audited monthly by the Blood Administration PI RN (5th Floor Nurse Manager) to ensure the patient's signed consent form was obtained prior to the administration of any blood products. The Blood Administration PI RN (5th Floor Nurse Manager) will also monitor the re-education of staff nurses on the blood product administration policy and procedure. The Blood Administration PI RN (5th Floor Nurse Manager) will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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S001014	<p>and 2) Unit #2, administered on 5/06/14 at (no time), was dated 5/07/14 which was 1 day after each of these 2 blood administrations.</p> <p>3. On 5/19/14 at 2:50 p.m., staff member #10 acknowledged that the above-listed patient had received two blood units without benefit of completed, per policy, consent forms prior to administration of these blood units.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(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.</p> <p>Based on observation, staff interview and document review, the facility failed to ensure medications were labeled</p>	S001014	S 1014 On 06/12/2014, the Director of Pharmacy re-educated all directors on the current policy	06/21/2014			

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	<p>according to facility policy for 3 medication vials in 2 departments.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During tour of the rehabilitation department beginning at 1:55pm on 5/19/14, in the presence of A4, A5 and P2, the following was observed in the medication storage cabinet: 2 open Flucinonide 0.05% vials each with an auxiliary label dated 8/15. 2. In interview on 5/19/14 at 2:00pm, staff member P2 indicated the month/year labeling to be standard in the department. The facility policy for medication labeling was requested at that time. 3. During tour of the wound care department beginning at 3:15pm on 5/19/14, in the presence of A4, A5 and S1, the following was observed in the medication storage cabinet; 1 multiple dose vial (MDV) Xylocaine 1% 20ml MDV with auxiliary label dated 4/14/14. 4. In interview on 5/19/14 at 3:15pm, employee S1 indicated labeling to be the date the vial was opened and it would expire 30 days after that date. S1 further indicated department staff to be aware of this process because "that's what I told them." 		<p>and procedure for expiration date labeling of multi-dose vial medication. Multi-dose medication vials will be sent from the pharmacy with a label attached for the person opening the vial to fill in the correct expiration date (28 days after opening). He also reminded directors that there is an expiration date calculator on the hospital intranet site to aid with date calculation. He instructed all directors to re-educate their staff that handle medications regarding this policy and procedure by 06/21/2014. On 06/13/2014, the Pharmacy Operations Coordinator provided re-education via email for all nursing staff on the current policy described above. Included in the email was a summary of the current policy, a copy of the current policy, and a demonstration of the expiration date calculator on the hospital intranet site. Also included in the email was a summary of the hospital policy on correct expiration dates for non-injectable multi-dose medications. Reference is made in the survey report to finding "2 open Flucinonide 0.05% vials each with an auxiliary label dated 08/15" in the physical medicine department (incorrectly referred to as the rehabilitation unit in the report). It must be noted that Flucinonide 0.05% is a cream and not an injectable medication. The</p>	

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S001024	<p>5. Facility policy titled "MEDICATION STORAGE AND LABELING" stated on page 2, number 7; Manufacturer's multiple dose vials (MDV) will be used for not more than 28 days from the date of first use or the manufacturer-assigned expiration date, whichever is shorter. All MDV will be sent from Pharmacy with an auxiliary label affixed to the vial which reads. " DO NOT USE AFTER _____ ". At the time the vial is first used, the person opening the vial will write a date which is 28 days from the current date. Upon subsequent use, personnel will verify that neither the manufacturer-assigned expiration date nor the 28 day in-use expiration date have past.</p> <p>6. In interview on 5/21/14 at 3:30pm, employee A5 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(C)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p>		<p>auxiliary expiration date label placed on the tube of cream was done for ease of expiration date inspection. Per hospital policy, the expiration date for multi-dose non-injectable medications is the manufacturers expiration date, not 28 days. In his email of 06/13/2014, the Pharmacy Operations Coordinator also re-educated staff on this policy and that the correct labeling of auxiliary expiration dates should be in the format of mm/dd/yyyy. When, for non-injectables, the manufacturer states the expiration date in MM/YYYY format, then the last day of the expiration month is considered the expiration "date". During monthly pharmacy nursing unit inspections, the pharmacy will audit 100% of opened multi-dose vials for correct labeling with correct expiration date in order to ensure that outdated, misdated, or otherwise unusable drugs are removed from general inventory. The Pharmacy Operations Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(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.</p> <p>Based on observation, document review and staff interview, the facility failed to ensure quarantine of 9 outdated drugs from general inventory in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> During tour of the wound care department beginning at 3:15pm on 5/19/14, in the presence of A4, A5 and S2, the following was observed in the medication storage cabinet; 9 Lidocaine HCL 2% and Epinephrine 1:100,000 vials with manufacturer expiration date 1 Dec 2013. In interview on 4/19/14 at 3:15pm, staff member S2 confirmed the above medications to be expired and available in general inventory. The policy on storage and removal of expired medications/drugs was requested 	S001024	S 1024 Per hospital policy titled OUTDATED MEDICATIONS WITHIN PHARMACY DEPARTMENT, procedure section titled "Unit Inspections", nursing stations will be checked monthly for outdated items with replacement effected immediately. As the Wound Care Department was a relatively new service, they had inadvertently not been added to the list for monthly pharmacy inspection. On 06/10/2014, the Pharmacy Operations Coordinator added the Wound Care Department to the monthly inspection list. Pharmacy inspection of the Wound Care Department for expired medication began on 06/16/2014. 100% of medications in the Wound Care Department will be inspected for expiration date each month by the pharmacy department to ensure that outdated or otherwise unusable drugs are removed from general inventory. The Pharmacy Operations Coordinator will be responsible for monitoring these	06/21/2014

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	<p>at that time.</p> <p>3. Review of the facility policy titled Monthly Unit Inspections, under the section titled PURPOSE, stated, This policy ensures that all medications available for administration to patients are not expired, stored appropriately and in usable condition.</p> <p>4. Review of the facility policy titled OUTDATED MEDICATIONS WITHIN PHARMACY DEPARTMENT, in the subsection titled IMPLEMENTATION 4. States Nursing stations will be checked monthly for outdated items with replacement effected immediately. Refer to procedure titled "Unit Inspections".</p> <p>5. In interview on 5/21/14 at 3:30pm, employee A5 confirmed the above and no further documentation was provided prior to exit.</p>		<p>corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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S001118	<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, product labeling and interview, the hospital created a condition which resulted in potential hazard to employees in 1 instance and failed to ensure safety of food products in 15 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 5/19/14 at 2pm in the presence of employees A4, A5 and P2, it was observed in the clean storage closet of the rehabilitation unit, cleaning chemicals RTU - Multi enzymatic foaming cleanser, Mueller 	S001118	S1118 The Director of Physical Medicine has coordinated with the Director of Engineering to install an eye wash station in the clean storage closet of the Physical Medicine department (incorrectly referred to as the rehabilitation unit in the survey report). The eye wash station will be connected to an internal water supply source and capable of continuous flow. Installation of the eye wash station is scheduled to begin on 06/12/2014 with a completion date of 06/18/2014. The Director of Physical Medicine will conduct education on the placement and operation of the eye wash station with all	06/19/2014

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591
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	<p>Whizzer, and Wexcide 128. Each respective label indicated use precautions and recommended eye flush in case of exposure. The RTU - Multi enzymatic foaming cleanser recommended flush with plenty of water, the Mueller Whizzer and Wexcide recommended a 15 - 20 minute flush. An eye wash station was not observed in the area.</p> <p>2. In interview on the above date and time, staff member P2 indicated the unit did not have an eye wash station and the chemicals noted were used by staff for instrument cleaning.</p> <p>3. On 5/19/14 at 2:15pm in the presence of employees A4, A5 and P2, outdated foods were observed in drawers of the kitchen area as follows: 7 jars Gerber baby food with expiration dates as follows: 1 - Exp. 31Oct13, 4 - 20Nov13, 1 - Dec13, 1 - Jan14, 1 container Chef Boyardee Spaghetti and Meatballs Jun282013, 1 container Chef Boyardee Beef Ravioli Jun082013, 1 can Thick and Easy Iced Tea 11-13-13, 1 box Country Corn Flakes Oct 2013, 1 8oz.</p>		<p>Physical Medicine staff by 06/16/2014. Inspection for proper functioning of the eye wash station will be conducted weekly as part of the departmental surveillance report. The Director of Physical Medicine immediately removed all expired patient food from the Physical Medicine Department staff area on 05/19/2014 and implemented a new policy, effective 06/09/2014, that only patient food stocked in the proper location, rotated, and inspected for expiration date by Good Samaritan Hospital Food Service will be maintained for patient use. The examination/confirmation of expiration dates on patient food, and disposal of expired food stores, was added to Physical Medicine's monthly departmental surveillance report on 06/19/2014. 100% of current staff and 100% of future staff during orientation will receive education on the use of the eye wash station in the clean storage closet in the Physical Medicine department. The eye wash station will be inspected weekly by the Director of Physical Medicine for proper functioning. 100% of patient food in the Physical Medicine staff area will be maintained and inspected by GSH Food Service and will also be inspected for expiration dates each month as part of the department surveillance report. The Director of Physical</p>	

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S001124	<p>bottle Thick-It 4-24-14, 2 cans Campbell's Spaghetti O's Feb 06 2014 and a 4 pack of Jell-O Snack Pack Feb 12 2014.</p> <p>4. In interview on 5/19/14 at 2:15pm, employee P2 indicated the above noted food items were on the unit available for patient use and confirmed the expiration dates of the items.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(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.</p>		Medicine will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	<p>Based on observation and interview, the facility failed to have available manufacturer operation and maintenance manual or instructions in 2 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During tour of the radiation and oncology unit beginning 4/20/14 at 11:20am in the presence of A5, S3 and S4, a Pedigo P-20-10s blanket warmer, facility identification (ID) number 32915, was observed with the temperature indicator beyond the highest measurable temperature of 220 degrees Fahrenheit. Upon opening the unit it was noted to have a hot odor. The temperature log, preventative maintenance (PM) documentation and manufacturer manual were requested at that time. 2. During tour of the radiation and oncology unit beginning 4/20/14 at 11:20am in the presence of A5, S3 and S4, in a room indicated to be the block cutting room, a Labconco Protector Laboratory Hood with a lit power indicator light was observed. Inspection logs, preventative maintenance documentation and the 	S001124	<p>It is the policy of the engineering department to maintain manufacturer's manuals in the Engineering technical literature library for all equipment brought into the facility that will placed on a preventative maintenance schedule. The 2 devices cited in the survey report had been in service for a long period of time and the manufacturer's manuals could not be found during the survey. On 06/06/2014, the Director of Engineering was able to locate copies of the manufacturer's manual for both devices cited in the survey report and placed copies of them in the Engineering technical literature library. Review of the manuals and the preventative maintenance schedule for both pieces of equipment indicated that routine maintenance and inspection was being completed more frequently than the manufacturer's recommendation. The Biomedical Engineering Supervisor will ensure that 100% of operator/service manuals for new medical equipment brought into the hospital are placed in the Engineering technical literature library. The Director of Engineering will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	06/21/2014	

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	<p>manufacturer manual were requested at that time.</p> <p>3. In interview on the above stated date and time, staff member S4 indicated no temperature logs were kept for the Pedigo blanket warmer and no manual was available, the Labconco hood was utilized to provide exhaust during molding and cutting of blocks used in departmental equipment. Staff member S4 further indicated no logs were kept relative to general inspections or maintenance of the hood and was unaware of having a manual within the facility.</p> <p>4. Review of documents on 5/21/14 indicated PM was being done for the two above listed pieces of equipment, but without manual unable to determine if PM was in accordance with manufacturer recommendations or if periodic inspections and testing were needed.</p> <p>5. In interview on 5/21/14 at 3:30pm, employee A5 confirmed the above and no further documentation was provided prior to exit.</p>			

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S001172	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation and document review, the facility failed to maintain a clean environment as per policy in 1 instance.</p> <p>Findings:</p> <p>1. On 5/20/14 at 9:30am in the presence of employee A5 during tour of the clean linen laundry area, heavy dust/lint globs were observed on top of equipment, on the ceiling and on objects hanging from the ceiling. A glove atop a flat surface across from open bins of clean, wet</p>	S001172	S1172 On the evening of 05/20/2014 the laundry area was given a "terminal" cleaning to remove all dust and lint. This cleaning included: wiping down all cables, hooks, and flat surfaces with a germicidal solution to remove dust as well as vacuuming and mopping the laundry area floor. On 05/20/2014 a laundry area cleaning/inspection "check off" list was created by the Director of Environmental Services/Laundry for the Laundry Supervisor to complete and turn in to	06/13/2014
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	<p>laundry and near the folding area was notably covered in heavy dust/lint; a large hanging hook in the same area was heavily coated in thick white dust.</p> <p>2. Review of the facility document entitled Laundry and Linen Room Department Policies, in GENERAL POLICY: 10, it is written; The laundry shall be processed in a clean and orderly environment.</p>		<p>Environmental Services every Friday by noon to ensure that the laundry area is maintained as a clean environment. The laundry area will be maintained as a clean environment through weekly (or more frequently as needed) cleaning and inspection. 100% of the laundry area cleaning/inspection forms will be completed by the Laundry Supervisor and reviewed by the Director of Environmental Services/Laundry to ensure compliance. The Director of Environmental Services/Laundry will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		