

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER RUSH MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 N MAIN ST RUSHVILLE, IN 46173
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005082</p> <p>Survey Date: 1-21/23-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 01/31/14</p>	S000000		

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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S000330	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(K)</p> <p>(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: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on document review and interview, the facility failed to maintain personnel records per facility policy / procedure for each employee of the hospital which included tuberculin tests for 14 of 22 personnel files reviewed (Staff #N2, N3, N4, N5, N6, N7, N8, N12, N13, N14, N16, N17, N19 & N20).</p> <p>Findings include:</p> <p>1. Review of policy / procedure Pre-Employment Health Evaluation and Annual Surveillance indicated the following;</p>	S000330	<p>S- 330 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Infection Control Department will finish an assessment for TB for our surrounding counties. Once the assessment is complete, a recommendation will be given to the Infection Control Committee. Once discussed, there will be a recommendation for a policy change, if needed, and then forwarded to Administration Committee. 2. How are you going to prevent the deficiency from recurring in the future? Once the policy is put in place, the Employee Health Coordinator</p>	03/31/2014			

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S000554	<p>"All employees are then required to have annual latex and TB screening completed each March." This policy / procedure was last reviewed / revised on 02-20-13.</p> <p>2. Review of staff #N2, N3, N4, N5, N6, N7, N8, N12, N13, N14, N16, N17, N19 & N20's personnel files lacked documentation of having annual TB screening in 03-13.</p> <p>3. On 01-22-14 at 1210 hours, staff #43 & 44 confirmed the facility is not performing annual TB screenings for employees.</p> <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 document review, observation and interview, the facility failed to follow the manufacturer's instructions for utilizing Cidex OPA Solution Test Strips in 1 instance.</p> <p>Findings:</p> <p>1. Review of the manufacturer's instructions for utilizing Cidex OPA</p>	S000554	<p>will monitor the policy to ensure it is followed with annual audits.</p> <p>3. Who is going to be responsible for numbers 1 and 2 above? The Employee Health Coordinator 4. By what date are you going to have the deficiency corrected? The assessment should be completed by February 28, 2014. The Infection Control Committee meets on March 20, 2014. The recommendation will be forwarded to the Administrative Committee meeting on March 25, 2014. Policy should be updated, if needed, by March 31, 2014</p> <p>S554 – 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Cidex OPA Solution Test Strips Policy & Procedure has been revised. The staff has been educated on the policy and the revisions made to it. The revisions include the manufacturer's instructions with the Cidex OPA Solution Test</p>	01/23/2014	

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	<p>Solution Test Strips indicated to always note the date the bottle was opened and the "do not use after date" in the space provided on the bottle. The instructions also indicated to prepare and test both a positive and negative control solution on each newly opened test strip bottle of CIDEX OPA Solution Test Strips.</p> <p>2. Observation of an open test strip bottle currently being used indicated there was no "do not use after date" written on the bottle.</p> <p>3. Review of a document entitled Endo-Vaginal Probe Disinfection did not indicate specifically, when a new bottle was opened, that both a positive and negative control test had been performed.</p> <p>4. In interview, on 1-21-14 at 2:15 pm, an ultrasound staff member confirmed the above was not documented.</p>		<p>Strips. 2. How are you going to prevent the deficiency from recurring in the future? The Director of Imaging will monitor the Cidex OPA Solution Testing Log on a monthly basis. The review of the Cidex OPA Solution Testing Log will become a quality improvement monitor. 3. Who is responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The ultrasound staff is responsible for following the Cidex Solution Test Strips Policy & Procedure. The Director of Imaging is responsible for ensuring the staff is following the protocol correctly. The Director of Imaging is responsible to monitor the log to be sure it's completed fully and correctly. 4. By what date are you going to have the deficiency corrected? January 23, 2104 a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. This has been corrected as of January 22, 2014. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases. N/A (Included: Cidex OPA Solution Test Strips Policy & Procedure and Cidex OPA Solution Testing Log)</p>		

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S000592	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(i)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following:</p> <p>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on document review and interview, the facility failed to ensure staff followed established policy / procedures for sanitation in one instance.</p> <p>Findings include:</p> <p>1. Review of policy / procedure Housekeeping Department Infection Control Policy indicated the following: "B. Resilient Floor Surfaces 1. Floors shall be cleaned with an EPA registered disinfectant detergent solution." This policy / procedure was last reviewed / revised on 01-12-12.</p> <p>2. On 01-21-14 at 1435 hours, staff #50</p>	S000592	<p>S592 1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. In a mandatory Staff meeting with the Environmental Services Department, the Director of the department will train the entire staff that Stride is not a disinfectant. Also, the use of bleach will be replaced with the EPA registered disinfectant "Virex II 256". The entire staff will be instructed on the proper use of the disinfectant. Virex II 256 will be used in all patient care areas to disinfect resilient floor surfaces. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? All Environmental Services staff</p>	02/22/2014	

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	<p>confirmed that he/she adds a cap full of bleach to Stride floor cleaner and water.</p> <p>3. Review of the Stride manufacturer's label lacked documentation that Stride was an EPA registered disinfectant detergent solution.</p> <p>4. On 01-22-14 at 1155 hours, staff #51 confirmed that Stride was not a disinfectant and housekeepers are not to mix bleach with other chemicals. The bleach is supposed to be mixed at a 1% ratio with water only.</p>		<p>members will be adequately trained and documented on how to use Virex II 256. During future staff meetings the staff will be given refresher training on its proper use. During the monthly housekeeping inspections the housekeepers will be observed when preparing their mop water to ensure they are preparing it correctly. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility Director will be responsible for Items 1 & 2 above. 4. By what date are you, the provider, going to have the finding and/or deficiency corrected? The deficiency mentioned above is anticipated to be corrected by February 22nd 2014. Plan of action: 30 day period (January 23rd 2014 through February 22nd 2014): In a staff meeting, the staff will be instructed not to use Stride as a disinfectant and to not mix chemicals in their mop water. The group will also be trained on the proper use of virex II 256 when disinfecting resilient floors.</p>		

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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 document review, observation and interview, the facility failed to ensure that unauthorized individuals cannot gain access to patient medical records (MR) for 2 areas (Out Patient Surgery & Infusion Clinic).</p> <p>Findings include:</p> <p>1. Review of policy / procedure Storage and Retrieval Systems indicated the following: "Storage space shall be selected and maintained to protect records from unauthorized access, loss and</p>	S000726	S 726- 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A locked filing cabinet in which MR's will be kept has been placed in Out Patient Surgery area effective January 30, 2014. 2. How are you going to prevent the deficiency from recurring in the future? Educate the staff the cabinet is to be locked at all times. 3. Who is going to be responsible for numbers 1 and 2 above? The director will oversee the compliance of making sure the cabinet is locked. 4. By what	01/30/2014			

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S000732	<p>inadvertent destruction." This policy / procedure was last reviewed / revised on 04-13.</p> <p>2. On 01-22-14 at 0915 hours during the tour of the Out Patient Surgery area, a filing cabinet with MRs was observed.</p> <p>3. On 01-22-14 at 0915 hours, staff #42 confirmed the filing cabinet does not lock.</p> <p>4. On 01-22-14 at 1050 hours during the tour of the Infusion Clinic area, an open shelf was observed containing MRs.</p> <p>5. On 01-22-14 at 1050 hours, staff #47 confirmed the MRs could sit in the open shelf for days at a time.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based on interview, the hospital failed to document in the medical record the course of each treatment of patients and</p>	S000732	<p>date are you going to have the deficiency corrected? Was corrected January 30, 2014. 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A locked filing cabinet in which MR's will be kept is in been place in the Infusion Clinic area effective January 23, 2014. 2. How are you going to prevent the deficiency from recurring in the future? Educate the staff all MR's are to be locked in the cabinet at all times. 3. Who is going to be responsible for numbers 1 and 2 above? The director will oversee the compliance of making sure the cabinet is locked. 4. By what date are you going to have the deficiency corrected? Was corrected January 23, 2014.</p> <p>S732 – 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of</p>	02/12/2014			

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	<p>results in 1 instance.</p> <p>Findings:</p> <p>1. In interview, on 1-22-14 at 11:15 am, hospital staff in the Massage Therapy area was requested to provide documentation of each treatment given to patients and results of the treatment. The employee indicated no such documentation was made for inclusion into the medical record.</p>		<p>correction. The Massage Therapy patient documentation forms have been created. The Initial Treatment Evaluation form will include documentation from the patient of; identifying the patient, medical history, primary reason for massage, problem area, and pain rating. The Initial Treatment Evaluation form will be completed by the patient and reviewed by the Massage Therapist prior to the onset of the first massage. The Intake form will include documentation of; identifying the patient, chief complaint, treatment tolerance and result, duration, and post-massage instructions given to patient, and additional notes of course of treatment as it applies to the patient's massage. The Intake form will be documented on every patient at each massage. Both forms will be included in the medical record. This new process of documentation will begin Wednesday, February 12, 2014.</p> <p>2. How are you going to prevent the deficiency from recurring in the future? The Director of Rehabilitation Services will review the documentation by randomly selecting 10 patients. The Director of Rehabilitation will review for complete documentation of the above stated requirements. This review of documentation will become a quality improvement monitor.</p> <p>3. Who is responsible for numbers 1 and 2 above; i.e.,</p>		

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			director, supervisor, etc.? The Massage Therapist is responsible for documenting on each patient that receives a massage. The Director of Rehabilitation Services will be responsible to review the patient documentation for complete required documentation. 4. By what date are you going to have the deficiency corrected? February 12, 2014 a. You must provide a specific date the deficiency will be or has been corrected (month, day, year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey. This will be corrected on February 12, 2014. b. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases. N/A (Included: Massage Therapy Initial Treatment Form and Massage Therapy Intake Form)		

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S000952	<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). Based on policy/procedure review, transfusion record review, and staff interview, the facility failed to follow approved medical staff policies and procedures for the administration of 1 of 7 transfusions reviewed.</p> <p>Findings include: 1. On 1/21/14 review of Policy/Procedure labeled "Blood and Blood Product Administration, Section Number: 1115, Revision Date: 1/2010" indicated: "PROCEDURE: Obtain vital signs and record on the transfusion form. Patient must be free of dizziness, itching, Don unsterile exam....Remove protective... Invert blood..... Open clamp.....Prime the blood side....Insert tubing....Swab access port.....Secure administration tubing....Open regulator Clamp....Start transfusion." 2. On 1/22/14 Between 1:00 p.m. and</p>	S000952	S-952 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A reminder was sent to staff immediately regarding the policy and procedure of blood transfusions and completing the forms appropriately. Director will review policy and educate staff during staff meeting on February 11, 2014. 2. How are you going to prevent the deficiency from recurring in the future? Yearly training regarding policy and procedure and completion of blood transfusion forms will occur. All blood transfusion forms will be reviewed by second nurse. 3. Who is going to be responsible for numbers 1 and 2 above? The director will oversee the compliance of the review and training. By what date are you going to have the deficiency corrected? February 11, 2014	02/11/2014			

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S001118	<p>4:00 p.m. review of transfusion records indicated T(Transfusion)#6 had the pre vitals recorded at the same time (14:10) as the transfusion was started instead of before the transfusion was started.</p> <p>3. In interview on 1/22/14 at 3:30 p.m. SP (Staff Person) #3 acknowledged the policy/procedure was not followed for T#6.</p> <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, the hospital created a condition which resulted in a hazard to patients, public or employees in 3 instances.</p> <p>Findings:</p> <p>1. On 1-21-14 at 12:30 pm, in the presence of employees #A5 and #A6, it was observed in the maintenance shop, there were 2 small gas cylinder tanks stored upright on the floor unsecured by</p>	S001118	<p>S1118 1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>a. The 2 small gas cylinder tanks observed to be unsecured in the maintenance shop were immediately secured to the wall with a chain. This was done on January 23rd 2014.</p> <p>b. The 4 large nitrous oxide gas cylinder tanks that were unsecured in the medical gas storage room were immediately</p>	01/23/2014			

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	<p>chain or holder.</p> <p>2. On 1-21-10 at 1:30 pm in the presence of employees #A5 and #A6, it was observed in the medical gas storage room, there were 4 large nitrous oxide gas cylinder tanks stored upright on the floor unsecured by chain or holder.</p> <p>3. If any of the above gas cylinder tanks were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p> <p>4. On 1-22-14 at 10:15 am, in the presence of employees #A5 and #A6, it was observed in the reception area of the RMH Women's Health Care offsite, there was an alcohol-based hand sanitizer (ABHS) used in an area that was carpeted and had no overhead water sprinkler.</p> <p>5. The use of an ABHS in an area carpeted and without an overhead water sprinkler posed a fire hazard if the alcohol substance got into the carpet.</p>		<p>secured with the chain presently next to the tanks. This was corrected on January 23rd 2014.</p> <p>c. The Alcohol based hand sanitizer found in the RMH Women's Health Care facility was removed from the building immediately. This was corrected on January 23rd 2014. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?</p> <p>a. The maintenance staff have been instructed to never leave a gas cylinder tank unsecured. Inspections will be conducted in the maintenance shop to ensure all gas cylinders are secure.</p> <p>b. The maintenance staff have been instructed to always make sure the medical gas tanks are secure with the wall chain. Future inspections will be conducted to ensure the chain is in place securing the gas cylinders.</p> <p>c. Inspections will be conducted throughout all non-sprinkled areas with carpeting to assure no ABHS (Alcohol based hand sanitizers) are present. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility Director will be responsible for Items 1 & 2 above. 4. By what date are you, the provider, going to have the finding and/or deficiency corrected? The deficiencies mentioned above have all been corrected on January 23rd 2014.</p>		

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S001150	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (c)(9)</p> <p>(c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.</p> <p>Based on observation, the hospital failed to install a backflow prevention device as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance.</p> <p>Findings:</p> <p>1. On 1-21-14 at 3:15 pm in the presence of employees #A5 and #A6, it was observed in a housekeeping storage closet there was a flexible hose connected to a water spigot without a backflow prevention device.</p>	S001150	<p>S1150 1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>To correct the observation immediately, the flexible hose was immediately disconnected from the spigot and removed from the area. To prevent a possible reoccurrence, the spigot will be replaced with one that will have a backflow preventer. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? A facility inspection will occur throughout all the buildings to verify that all spigots requiring a hose attachment will have a backflow preventer. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility Director will be</p>	02/22/2014	

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S001162	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(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:</p> <p>(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.</p> <p>Based on document review and interview, the hospital failed to document annual preventive maintenance (PM) of 1 piece of mechanical equipment in accordance with the manufacturer's recommended</p>	S001162	<p>responsible for Items 1 & 2 above. 4. By what date are you, the provider, going to have the finding and/or deficiency corrected? The deficiency mentioned above is anticipated to be corrected by February 22nd 2014. Plan of action: 30 day period (January 23rd 2014 through February 22nd 2014): The spigot will be replaced with one with a backflow preventer. A facility inspection will be conducted to assure all spigots (with a hose attachment) will have a backflow preventer</p> <p>S1162 1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The Nobels Speed Scrub floor scrubber preventative maintenance schedule will be</p>	02/22/2014	

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	<p>maintenance schedule.</p> <p>Findings:</p> <p>1. Review of the manufacturer's recommended maintenance schedule for the Nobles Speed Scrub 2001 HD floor scrubber indicated monthly checks every 80 hours operation should be performed as follows:</p> <p>MACHINE - Inspect for loose nuts, bolts and water leaks. PIVOT POINTS - Lubricate with a water resistant oil. FRONT CASTERS - Lubricate each caster grease fitting with a water resistant grease.</p> <p>2. Review of facility policy and procedure P.P. #0005, entitled <i>Housekeeping Floor Care Equipment Preventive Maintenance</i>, indicated a monthly inspection of all floor care equipment will be performed. This inspection will cover both electrical and mechanical systems. A checklist will be followed that will describe all items to be checked. See Atch Checklist.</p> <p>3. Review of the attached checklist indicated Items to check: proper operation, cut or damaged cords and plugs, damaged or broken housing,</p>		<p>revised to be a more detailed PM plan which will include the appropriate frequency of the manufacturer's recommended maintenance schedule. It will also include detailed information on what is being checked per the manufacturer's recommendations. Upon completion of the revised PM, the maintenance department will be trained on the changes to assure the PM is done in an accurate and timely manner. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? The Facility Director (or Maintenance Supervisor) will conduct a monthly check to assure that the PM has been done and documented per state regulations. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility Director will be responsible for Items 1 & 2 above. 4. By what date are you, the provider, going to have the finding and/or deficiency corrected? The deficiency mentioned above is anticipated to be corrected by February 22nd 2014. Plan of action: 30 day period (January 23rd 2014 through February 22nd 2014): A revised PM schedule will be established and the maintenance department will be trained on the changes.</p>		

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S001164	<p>check to insure proper vacuum on sweepers, take bottom plate off sweepers and clean brush and airway.</p> <p>4. Review of the Monthly Checklist dated 8-16-13, did not indicate PIVOT POINTS lubrication and FRONT CASTERS lubrication.</p> <p>5. In interview, on 1-23-14 at 10:15 am, employee #A5 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(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: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review, the hospital failed to provide evidence of preventive maintenance (PM) for 4 pieces of equipment.</p>	S001164	<p>S1164 1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Preventative</p>	02/22/2014

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	<p>Findings:</p> <ol style="list-style-type: none"> On 1-21-14 at 1:05 pm, employee #A5 was requested to provide documentation of PM on an arm ergonometer machine in the Cardiac Rehab area. On 1-21-14 at 1:35 pm, employee #A5 was requested to provide documentation of PM on a set of parallel bars, an overhead hand pulley exerciser, and a Paramount MP Series piece of equipment, all located in the Physical Therapy area. No documentation was provided prior to exit. 		<p>maintenance plans will be created for the following pieces of machinery: Arm ergonometer (Cardiac Rehab), Parallel bars (Physical Therapy), Overhead hand pulley exerciser (Physical Therapy) and the Paramount MP exercise piece of machinery (Physical Therapy). The preventative maintenance plans will include the appropriate frequency of the manufacturer's recommended maintenance schedule. They will also include detailed information on what is being checked per the manufacturer's recommendations. Upon completion of the revised PMs, the maintenance department will be trained on the changes to assure the PMs are done in an accurate and timely manner.</p> <ol style="list-style-type: none"> How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? The Facility Director (or Maintenance Supervisor) will conduct a monthly check to assure that the PMs have been done and documented per state regulations. Who is going to be responsible for numbers 1 and 2 above? The Facility Director will be responsible for Items 1 & 2 above. By what date are you, the provider, going to have the finding and/or deficiency corrected? The deficiencies mentioned above are anticipated 		

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S001168	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review, the hospital failed to properly keep a discharge log for 1 of 1 defibrillator.</p> <p>Findings:</p> <p>1. Review of the manufacturer's manual for the facility's defibrillator indicated there was an Operator's Shift Checklist for M Series Products (Semi-Automatic), to be performed at the start of each shift. The list included, but was not limited to, the following checks:</p> <p>Multi-function Pads - 1 set pre-connected / 1 spare Inspect cables for cracks, broken wires, connector - ECG electrode cable,</p>	S001168	<p>to be corrected by February 22nd 2014. Plan of action: 30 day period (January 23rd 2014 through February 22nd 2014): PMs will be established and the maintenance department will be trained on the changes.</p> <p>S-1168 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A reminder was sent to staff regarding completion of crash cart checks every shift. The check off sheet has been updated and put in use. 2. How are you going to prevent the deficiency from recurring in the future? Yearly training regarding policy and procedure and completion of crash cart checklist will occur. 3. Who is going to be responsible for numbers 1 and 2 above? The director will oversee the compliance of completed checklist. The shift supervisor will be responsible for assuring the checklist is completed daily. 4. By what date are you going to have the</p>	01/30/2014

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	<p>connector, defibrillator paddle cables, multi-function cable, connector Batteries - fully charged battery in unit, fully charged spare battery available</p> <p>2. Review of a document entitled ER CRASH CART CHECKLIST - TRAUMA BED B, for the dates 10-22-13 through 11-1-13, indicated that none of the above checks were documented.</p>		<p>deficiency corrected? Was January 30, 2014. Please see attached forms</p>		

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S001186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, it could not be determined the facility would properly handle and dispose of non-hazardous waste management in 1 instance and failed to follow its policy to conduct fire drills in 8 instances.</p> <p>Findings:</p> <p>1. On 1-21-14 at 11:15 am, employee #A5 was requested to provide documentation of a waste management</p>	S001186	<p>S1186 1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>a. A newly revised waste management policy will be written (and put into place) to include both the disposal of hazardous waste and non-hazardous waste. b. The RMH Pediatrics and RMH Women's Care Healthcare facilities will be implemented in the scheduling of fire drills. Each building will have a fire drill on a</p>	02/22/2014	

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	<p>(non-hazardous) policy.</p> <p>2. A document was presented by the facility, Section Number: 1207, entitled Hazardous Waste Management, Revision Date: 11/2011, indicated the Environmental Services Department is responsible for coordinating the hospital's disposal of hazardous waste. There was nothing in the policy documenting non-hazardous waste management.</p> <p>3. In interview, on 1-23-14 at 2:30 pm, employee #A5 confirmed the above and no other documentation was provided prior to exit.</p> <p>4. In interview, on 1-23-14 at 10:05 am, employee #A5 indicated the hospital policy was to conduct 1 fire drill per quarter per shift.</p> <p>5. Review of fire drills conducted by the facility for calendar year 2013, indicated there were none for the offsites of RMH Pediatrics and RMH Women's Healthcare.</p> <p>6. In interview, on 1-23-14 at 10:05 am, employee #A5 indicated the hospital had not performed the 4 required fire drills for each offsite and no other documentation was provided prior to</p>		<p>quarterly basis. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? a. The waste disposal policy will be reviewed biannually to verify its accuracy. b. The Facility Director (or Maintenance Supervisor) will assure that these two buildings are included in the fire drill schedule by reviewing the fire drill documentation on a monthly basis. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility Director will be responsible for Items 1 & 2 above. 4. By what date are you, the provider, going to have the finding and/or deficiency corrected? The deficiencies mentioned above are anticipated to be corrected by February 22nd 2014. Plan of action: 30 day period (January 23rd 2014 through February 22nd 2014): a. A waste management policy will be created. b. Fire drills will be conducted at the RMH Women's Care and RMH Pediatrics buildings on a quarterly basis.</p>		

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	exit.			