

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152020	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2013
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NAME OF PROVIDER OR SUPPLIER ST VINCENT SETON SPECIALTY HOSPITAL, INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 003350</p> <p>Survey Date: 3-12/14-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Linda Dubak, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: cloughlin 03/18/13</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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S000270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 18 contracted services.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year 2012 indicated they did not include review of reports for the following contracted services: Agency Nursing, Surgery, Anesthesiology, Recovery, Radiological Services (CT Scans, MRIs, Interventional Radiology, Ultrasounds, PET Scans, HidaScan/Idium Scan, Endoscopy Services, Nuclear Medicine, Cardiology (ECHO, CVU), CPD, Emergency Services, Laboratory, Pharmacy and Respiratory Services.</p>	S000270	The QA/PI Program has been update to include the quality monitoring activities of these contracted services. The Manager of Organizational Excellence is the responsible party for report of quality monitoring activities to Governing Board.	05/03/2013

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	2. In interview, on 314-13 at 11:40 am, employee #A4 confirmed the above and no further documentation was provided prior to exit.			

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S000318	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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:</p> <p>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care.</p> <p>Based on documentation review, the facility failed to ensure the Registered Dietician (L5) was CPR competent as per Dietary written procedure.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Contracted Dietary Service's CPR and Other Life Safety Training written policy #E014 requires dieticians receive life safety training. Staff member L5 Human 	S000318	All dietary policies and procedures will be updated and presented to PT/IC Committee for approval. The policy regarding Registered Dietician CPR competence will be changed to reflect Seton requirements for CPR competence. Seton does not require Registered Dietician to be CPR competent. The Safety Officer/Facilities Manager is the responsible party.	05/01/2013	

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	Resource files were reviewed. The staff member was an employee of the Dietary Contracted Service. Staff member L5 documentation lacked evidence of CPR competency.			

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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 furnished by a contractor.</p> <p>Based on document review and interview, the hospital failed to include monitors and standards for 17 services provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the contracted services as indicated in the MASTER SERVICES AGREEMENT between the facility and St. Vincent Hospital and Health Care Center, Inc., dated May 11, 2012: Surgery, Anesthesiology, Recovery, Radiological Services (CT Scans, MRIs, Interventional Radiology, Ultrasounds,</p>	S000406	The QA/PI Program has been update to include the quality monitoring activities of these contracted services. Quality indicators (monitors) for these contracted services have been incorporated into the quality dashboards. The Manager of Organizational Excellence is the responsible party.	05/03/2013			

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	<p>PET Scans, HidaScan/Idium Scan, Endoscopy Services, Nuclear Medicine, Cardiology (ECHO, CVU), CPD, Emergency Services, Laboratory, Pharmacy and Respiratory Services.</p> <p>2. In interview, on 3-14-13 at 11:40 am, employee #A4 confirmed the above and no further documentation was provided prior to exit.</p>			

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S000554	<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, the hospital created 1 condition which failed to provide a healthful environment that minimized infection exposure and risk to patients, employees and visitors.</p> <p>Findings:</p> <p>1. On 3-12-13 at 12:30 pm, in the presence of employees #A5 and #A6, it was observed in the hospital lobby, a light ledge containing many dead insects and dust.</p>	S000554	Light ledge cleaned during survey and added to preventative maintenance schedule for on-going routine cleaning. The Safety Officer/Facilities Manager is the responsible party.	03/15/2013			

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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.</p> <p>Based on document review and staff interview, the facility failed to ensure the Dietary Policies were approved by the Infection Control Committee for 11 Dietary polices reviewed.</p> <p>Findings included:</p> <p>1. St. Vincent Seton Specialty Hospital Formulation & Revision of Hospital Policies and Procedures (Last revised 6/2011) states, "Infection Control: All policies regarding Infection surveillance prevention and controls including</p>	S000592	All Touchpoint (Contracted Services) policies and procedures were reviewed and updated, as needed, by Dietary Leadership, Safety Officer and Infection Preventionist. Those policies and procedures applicable to St.Vincent Seton Specialty Hospital have been put in the correct format (i.e. PolicyStat) and submitted to PT/IC committee for approval. The next PT/IC Committee meeting if May 1, 2013. The Safety Officer/Facilities Manager is the responsible party.	05/01/2013			

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	<p>isolation system and any changes in cleaning routines or solutions need review by the hospital Infection Control Practitioner as well as hospital leadership. The final approval of these policies must be by the Pharmacy & Therapeutics/Infection Control Committee, as well as the Medical Executive Committee."</p> <p>2. At 2:00 PM on 3/12/2013, staff member L9 indicated contracted dietary policies on sanitation practices for the kitchen and cafeteria were never provided to him/her for review.</p>				

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S000596	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii)</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: (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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on documentation review, observation, and staff interview, the facility failed to ensure the Dietary Department was maintained in a clean and sanitary manner.</p> <p>Findings included:</p> <p>1. Contracted Dietary Service's Required Cleaning and Sanitization policy #F013 requires food-contact and non-food contact surfaces to be maintained clean and sanitary in the kitchen and the cafeteria. The chemical sanitizer used for food-contact surfaces was required</p>	S000596	All Touchpoint (Contracted Services) policies and procedures were reviewed and updated, as needed, by Dietary Leadership, Safety Officer and Infection Preventionist. Those policies and procedures applicable to St. Vincent Seton Specialty Hospital have been put in the correct format (i.e. PolicyStat) and submitted to PT/IC committee for approval. The next PT/IC Committee meeting if May 1, 2013. Dietary staff have began completeing training specific to proper hand hygiene, sanitation, labeling, etc. in regards to food sanitation, storage. Hand Hygiene training completed on March 14, 2013. Proper use of Quat Sanitizer training completed on March 21, 2013. Recording temperatures	05/01/2013			

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	<p>to meet the manufacturer's recommendations.</p> <p>2. At 10:00 AM on 3/12/2013, the kitchen was toured. The hand sink located in the kitchen next to the door entryway to the cafeteria was observed with a 55-gallon trash container with a lid on it. After staff washed their hands, the staff were observed opening the trash can's lid to discard the paper towels. This practice contaminated a person's hands after they have washed them by handling the soiled trash can lid. While touring the kitchen and the cafeteria, six wiping cloths were observed lying on prep counters surface table tops, deli cutting board and in a staff member's back pocket. The sanitizing wiping cloth rags were observed not stored in the OASIS 146 Quat solution between use of the cloths. During the tour of the kitchen and cafeteria on 3/12/13, three of three sanitizing wiping buckets that were used for food contact surfaces exceeded 500 ppm.</p>		<p>daily and labeling of food (name, date, expiration) training completed on March 26, 2013. Proof of associate training and competency will be maintained in the associate files. Touchpoint Leadership required to be on-site at Seton at least 4 times a week to ensure program success and adherence to policies and procedures. Touchpoint Leadership presence on-site at Seton began immediately (during survey) and has continued. These on-site visits will be a complimentary combination of short stops, inspections, team building and long day sessions at Seton to ensure staff are effective and efficient in their roles. Touchpoint leadership has implemented monthly quality inspections. Copies of these monthly inspections and action items implemented as a result of the inspections are provided to Seton. A quality indicator in regards to the monthly inspections have been added to the dashboard for quality reporting to the Board of Directors. The Safety Officer/Facilities Manager is the responsible party.</p>				

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	<p>The Dietary Department uses OASIS 146 Quaternary Ammonia. The Ecolab's recommendation range requirement is 150 to 400 ppm concentration.</p> <p>3. At 10:15 AM on 3/12/2013, a staff member was observed picking up a soiled rag off of the prep table in the kitchen and rinsing it out in the 3-compartment sink faucet's running water. After this step, the staff member wiped the same prep counter surface top and then laid the rag at the edge of the prep table. Then the staff member started to prepare another food item.</p> <p>4. At 10:30 AM on 3/12/2013, the operational fan located on the floor next to the diet line's steam table was observed with heavy accumulation of dirt and other soil debris caked on the blade guards.</p> <p>5. At 10:35 AM on 3/12/2013, the prep table located near the diet line was observed with a shelving rack above it which was storing spices</p>			

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	<p>and other miscellaneous food items. The shelf was observed sticky to touch and also had visual evidence of food spill on it.</p> <p>6. At 11:15 AM on 3/12/2013, the outside Walk-in Freezer was observed with heavy ice build-up on the floor covering approximately a 2-foot by 3-foot area on the floor; the ice build-up was approximately 6-inches thick. Accumulation of ice was also observed hanging from the condenser.</p> <p>7. At 12:00 PM on 3/12/2013, the exterior surfaces of the wood doors to the cabinets located behind the cafeteria serving line were observed with food smeared on them and were sticky to touch. The inside surfaces of the cabinets had evidence of several liquid spills. The inside surfaces were also sticky to touch and there was accumulation of dust and other loose food debris in them. Two cabinet doors located behind the</p>			

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	<p>serving line were observed either missing door handles or loose from the door hinges. The opening and closing of the cabinet doors were dropping to a point that the doors felt loose from their hinges.</p> <p>8. At 12:15 PM on 3/12/2013, the two refrigerated units located behind the cafeteria serving line were observed with heavy accumulation of food soil residue on the inside surfaces of the coolers. The coolers also had evidence of sticky liquid spill within them.</p>				

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S000608	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(ix)</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: (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>(ix) Requirements for personal hygiene and attire appropriate for work settings.</p> <p>Based on observation and document review, the facility failed to wash their hands between removing and changing single-use gloves in the Dietary Department.</p> <p>Findings Included:</p> <p>1. Contracted Dietary Service's Hand Hygiene policy #F007 stated, "All employees associated with the handling of food shall wash hands. Hands are washed with soap and water at the following times: Before each shift; Before handling</p>	S000608	All Touchpoint (Contracted Services) policies and procedures were reviewed and updated, as needed, by Dietary Leadership, Safety Officer and Infection Preventionist. Those policies and procedures applicable to St.Vincent Seton Specialty Hospital have been put in the correct format (i.e. PolicyStat) and submitted to PT/IC committee for approval. The next PT/IC Committee meeting if May 1, 2013. Dietary staff have began completeing training specific to proper hand hygiene, sanitation, labeling, etc. in regards to food sanitation, storage. Hand Hygiene training completed on March 14, 2013. Proper use of Quat Sanitizer training completed on March 21,	05/01/2013

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	<p>food or clean utensils/dishes/equipment; Before putting on gloves; After touching hair, skin, beard or clothing; After handling garbage; After removing gloves; After handling rags and mops; ..."</p> <p>2. During the tour of the kitchen and cafeteria at 10:00 AM on 3/12/2013, one of the kitchen staff members was observed wiping their gloved hands on their apron and not changing gloves and washing hands afterwards. Another kitchen staff member working behind the cafeteria serving line was observed at least 3 times changing gloves without washing his/her hands before putting on a new set of single-use gloves. A third staff member was observed wiping their prep table down with a sanitizer rag and did not wash their hands before putting on their single-use gloves. A fourth kitchen staff member was observed handling dirty vegetables during washing them and not washing their hands before putting</p>		<p>2013. Recording temperatures daily and labeling of food (name, date, expiration) training completed on March 26, 2013. Proof of associate training and competency will be maintained in the associate files. Touchpoint Leadership required to be on-site at Seton at least 4 times a week to ensure program success and adherence to policies and procedures. Touchpoint Leadership presence on-site at Seton began immediately (during survey) and has continued. These on-site visits will be a complimentary combination of short stops, inspections, team building and long day sessions at Seton to ensure staff are effective and efficient in their roles. Touchpoint leadership has implemented monthly quality inspections. Copies of these monthly inspections and action items implemented as a result of the inspections are provided to Seton. A quality indicator in regards to the monthly inspections have been added to the dashboard for quality reporting to the Board of Directors. The Safety Officer/Facilities Manager is the responsible party.</p>		

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	on a new set of single-use gloves.			

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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, documentation review, and staff interview, the facility failed to keep the outside walk-in freezer located in the rear of the hospital secured.</p> <p>Findings included:</p> <p>1. Contracted Dietary Service's Department Security Program policy #A011 stated, "The Food and Nutrition Services/Dining Services Department shall take appropriate measures to provide a protected working environment for staff, as well as to secure the environment, food, supplies, and cash." The policy included a Departmental Security Guidelines</p>	S001118	The outside walk-in freezer will be locked at all times. Random checks will be conducted to ensure compliance. The Safety Officer/Facilities Manager is the responsible party.	04/05/2013			

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	<p>and Checklist. The checklist included: All coolers, cabinets, and storage areas, can be individually secured; Storage and receiving areas are locked when not occupied by authorized employees;</p> <p>2. At 10:42 AM on 3/12/2013, the walk-in freezer was located in the rear of the hospital and was not attached to the hospital. The large door to the walk-in freezer was not locked and the door to the freezer was able to be opened. The walk-in freezer was located within 50-feet of the hospital parking lot. The freezer was not protected from any other wall or casing to maintain the security of the food that was stored in the freezer.</p> <p>3. At 2:15 PM on 3/12/2013, staff member L2 indicated the outside walk-in freezer is usually not locked during the day.</p> <p>4. At 2:30 PM on 3/12/2013, staff member L9 indicated the walk-in freezer should be locked when not</p>			

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	in use for the safety and security of product, staff, and visitors.			

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S001164	<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:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review, observation and staff interview, the facility failed to assure preventive maintenance (PM) was conducted on Physical Therapy's Electric Water Bath and failed to ensure CX50 Ultrasound System had its preventive maintenance according to the hospital's PM schedule.</p> <p>Findings included:</p> <p>1. On 3-12-13 at 11:15 am, while on tour with employees #A5 and #A6, it was observed in the Physical Therapy area there was an electric water bath. Staff was requested to provide documentation of preventive maintenance on the</p>	S001164	A preventive maintenance inspection has been conducted on the Physical Therapy's Electric Water Bath. The physical therapy electric water bath has also been added to the scheduled preventive maintenance inspections. The CX50 Ultrasound System preventive maintenance schedule has been changed to follow the original equipment manufacture recommendations for preventive maintenance schedule (annually). Seton has completed the PM for the CX50 Ultrashould System. The Safety Officer/Facilities Manager is the responsible party.	04/05/2013	

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	<p>equipment and no documentation was provided prior to exit.</p> <p>2. Philips Healthcare North America invoice noted the piece of healthcare equipment installed the CX50 Ultrasound System between 5/11/2012 through 5/14/2012.</p> <p>3. At 9:30 AM on 3/13/2013, staff member L8 indicated the CX50 Ultrasound System was on his/her Preventive Maintenance Schedule to be performed every 6 months.</p> <p>4. At 11:00 AM on 3/13/13, staff member L7 indicated Philips Warranty agreement requires the CX50 Ultrasound system to have a PM annually. The staff member confirmed the healthcare equipment was scheduled to be PM every 6 months; however, when a piece of equipment will be scheduled for preventive maintenance, the computer system will print a work order for the required PM. Staff member L7 investigated into the</p>			

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	location of the PM that should of been done in November 2012. At 1:00 PM on 3/13/13, staff member L7 indicated the piece of equipment was scheduled annually; however, at 10:57 AM on 3/13/2012 the CX50 Ultrasound system was changed in the computer to be completed in a 6 month cycle which was more stringent. Staff member L7 confirmed the record that was provided confirmed the piece of equipment should have had PM during the month of November 2012. Therefore, the CX50 Ultrasound system was 4 months late on its required preventive maintenance.				

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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 and interview, the hospital failed to properly keep a discharge log for 1 of 1 defibrillators in accordance with manufacturers recommendations.</p> <p>Findings:</p> <p>1. Review of the Zoll M Defibrillator manual indicated the Operator's Shift Checklist for M Series Products was recommended for checks and procedures to be performed at the start of each shift. The Checklist included, but was not limited to: Paddles - paddles clean, not pitted, release from housing easily Inspect cables for cracks, broken wires, connector - ECG electrode cable, connector, defibrillator paddle cables, multi-function cables, connector Batteries - fully charged battery in unit, fully charged spare battery available</p>	S001168	The code cart log sheet has been updated to include the manufacturers recommendations for the Zoll M Defibrillator. A copy of the manufacturers recommendations has been laminated and placed on the code carts for reference. Staff education completed the week of March 31-April 6, 2013. The Site-Administrator/CNO is the responsible party.	04/05/2013

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	<p>2. Review of a hospital policy entitled Code Cart maintenance - Indianapolis, last revised 01/2012, indicated no reference to the manual, Operator's Shift Check List, nor any other indication which included the Operator's Shift Check List items.</p> <p>3. Review of a document entitled Code Cart Integrity Sheet, Date: March, 2013, Code Cart Location: Pharmacy, indicated it did not include the above-stated checks.</p> <p>4. In interview, on 3-12-13 at 4:25 pm, employee #A3 confirmed the above and no further documentation was provided prior to exit.</p>			

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S001178	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (e)(2)</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>(2) Refuse and garbage shall be collected, transported, sorted and disposed of by methods that will minimize nuisances or hazards.</p> <p>Based on observation, the facility failed to dispose of refuse and garbage that minimized nuisances or hazards.</p> <p>Findings:</p> <p>1. On 3-12-13 at 11:00 am, in the presence of employees #A5 and #A6, it was observed at the outside trash compactor there was a considerable amount of trash and rubbish on the ground all around the compactor.</p>	S001178	The trash and rubbish was cleaned up during survey. It has also been added as a regulary scheduled preventive maintenance for on-going cleaning and compliance. The Safety Officer/Facilities Manager is the responsible party.	04/05/2013	

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S001197	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F)</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>(F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and interview, the hospital failed to have written documentation of a regular state or local fire inspection in 1 instance.</p> <p>Findings:</p> <p>1. Review of documents indicated there was no documentation or request for same in calendar 2012 of a regular state or local fire inspection.</p> <p>2. In interview, employee #A8 confirmed the above and no further documentation was provided prior to exit.</p>	S001197	The Safety Officer had completed a request via phone call for 2012 but had nothing in writing. This was corrected during survey as the Safety Officer submitted an e-mail request for a fire inspection for 2013. Fire inspection completed by the Local Jurisdiction having Authority (LJA), Pike Township Fire Department, on April 16, 2013, with no findings. The Safety Officer/Facilities Manager is the responsible party.	04/16/2013	