

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150046	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/19/2015
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S SEVENTH ST TERRE HAUTE, IN 47802
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S 0000 Bldg. 00	This visit was for a State hospital licensure survey. Dates: 8/17/2015 through 8/19/2015 Facility Number: 005042 QA: cjl 09/11/15	S 0000		
S 0392 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(f)(2) (f) The governing board is responsible for services delivered in the hospital whether or not they are delivered under contracts. The governing board shall insure the following: (2) That the services performed under a contract are provided in a safe and effective manner and are included in the hospital's quality assessment and improvement program. Based on document review and staff interview, the Governing Body failed to ensure the contracted housekeeping company was part of the hospital's quality and assessment and improvement program for 2 offsite locations.	S 0392	<u>Discussion:</u> The Governing Body failed to ensure the contracted housekeeping company was part of the hospital's quality and assessment and improvement program for 2 offsite locations (PDI and Pavilion).	10/01/2015

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>Findings included:</p> <ol style="list-style-type: none"> 1. Terre Haute Regional Hospital Governance Bylaws (last approved October, 2014) Article 7.6 Contracted Services, indicated the Board shall ensure that contracted services are performed safely and effectively through implementation and participation of contracted services in the performance improvement program. 2. The hospital has two offsite locations: Premiere Diagnostic Imaging Center (PDI) and Outpatient Rehab Center (OP). The two offsite locations use the same contracted housekeeping service. The hospital does not have documented evidence of monitoring and evaluating the effectiveness that the contracted housekeeping service provides to the offsite locations. 3. At 2:15 PM on 8/18/2015, staff member #5 (Quality Manager) confirmed the contracted housekeeping services have not been part of the hospital's quality improvement and performance program. 		<p><u>Corrective Action:</u> The Director of Environmental Services met with the housekeeping contractor on 9/1/2015 and discussed the Facility QAPI program and our Facility's quality expectations. QAPI monitoring of off-site housekeeping was incorporated into the Facility Quality Dashboard on 9/1/2015 by the Regulatory Survey Coordinator. See Attachment A.</p> <p><u>Compliance Monitoring:</u> Regulatory Survey Coordinator will perform weekly random walk-through observations of off-site housekeeping performance to validate EVS Director's evaluation of quality for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p><u>Implementation Date:</u> 10/1/2015</p> <p><u>Responsible Person(s):</u> Director of Environmental Services</p>		

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S 0554 Bldg. 00	<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 and staff interview, the hospital failed to ensure the eight operating rooms met the required temperature as defined by hospital policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Terre Haute Regional Hospital Engineering/Safety - Monitoring of Temperature and Humidity, policy ENG.101.201 (last revised 10/2014) indicated the optimum temperatures for the operating rooms are 68 to 75 degrees Fahrenheit (F). The hospital shall comply with the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on temperature and humidity ranges for perioperative settings. 2. AORN (Association of periOperative Registered Nurses) supports the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on 	S 0554	<p><u>Discussion:</u> The hospital failed to ensure the eight operating rooms met the required temperature as defined by hospital policy.</p> <p><u>Corrective Action:</u> Education was provided to all Plant Operations Staff on 9/3/2015 by the Director and Manager of Plant Operations during a departmental meeting as a reminder to investigate any out of range temperature alarms. Plant Operations staff review remote temperature monitors daily and will monitor alarm if temperatures are out of range. Daily rounding of the Air-Handler is to be performed every 3 hours. The temperatures are on a computerized monitoring program. This system will alarm HVAC technicians in the event the temperatures are out of the designated range. The Technicians will take appropriate action to get the temperature in the OR to design specification. This education was to re-enforce the requirement that Operating Room Temperatures must remain between</p>	10/01/2015

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	<p>temperature and humidity ranges for perioperative settings. The operating rooms temperature range should be between 68 F and 73 degrees F, while the humidity should be between 30% and 60%.</p> <p>3. Staff member #12 provided the Temperature/Humidity logs for nine operating rooms. The nine operating rooms selected date period was from 7/11/2015 through 8/1/2015. Eight of the nine operating rooms are required to register between 68 and 75 degrees Fahrenheit: 1, 2, 3, 4, 5, 6, 7, and 9. The temperature for the eight operating rooms routinely registered below 66 degrees Fahrenheit. About 30% of the time, the temperature of the eight operating rooms registered below 62 degrees Fahrenheit. When the temperature of the operating rooms falls below 62 degrees Fahrenheit, the temperature/humidity log evidenced same effect for the humidity to rise above 60%.</p> <p>4. At 2:15 PM on 8/19/2015, staff member #12 (Director of Support Services) confirmed eight of nine operating rooms routinely do operate under 67 degrees Fahrenheit.</p>		<p>68-75 degrees F at all times and that Plant Operations department must be notified if temperatures cannot be maintained in that range. See Attachment C.</p> <p>-</p> <p><u>Compliance Monitoring:</u> A random sample of 70 OR temperature log entries will be evaluated monthly times 3 months by the Regulatory Survey Coordinator to ensure that OR temperatures remain within normal limits and that corrective action is taken if temperatures fall out of range. Any discrepancies will be immediately reported to the Director of Plant Operations. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p><u>Implementation Date:</u> 10/1/2015</p> <p><u>Responsible Person(s):</u> Director of Plant Operations</p>	

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S 0610 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL</p> <p>410 IAC 15-1.5-2(f)(3)(D)(x)</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>(x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following:</p> <p>(AA) Storage of employee food in patient refrigerators.</p> <p>(BB) Medications in nutrition refrigerators.</p> <p>(CC) Refrigerator and freezer temperature monitoring.</p> <p>Based on observation, document review and staff interview, the facility failed to ensure high-protein Enternal tube-feeding supplements were stored properly in the Storeroom.</p>	S 0610	<p><u>Discussion:</u> The facility failed to ensure high-protein enteral tube-feeding supplements were stored properly in the Storeroom.</p> <p><u>Corrective Action:</u> 1. The Director of Supply Chain</p>	09/23/2015

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	<p>Findings included:</p> <p>1. At 11:05 AM on 8/18/2015, a rack in the Store Room was observed storing Abbott Enteral Feeding Supplements on wired shelves under florescent ceiling lights. The wire shelves containing assorted cases were observed with cardboard carton tops cut open exposing the plastic bottles in the cartons to the fluorescent lighting. The cut open assorted cases contained the following items: Osmolite 1.2 cal (calorie); Jevity 1.5 cal; Glucerna 1.0 cal; Jevity 1.0 cal.</p> <p>2. The manufacturer's product label of the assorted enternal ready-to-eat nutritional supplements states, "Contain light sensitive nutrients." The manufacturer indicates artificial light degrades vitamins such as riboflavin (B2), B6, and vitamin A. Vitamins losses occur gradually at low light exposure and faster in bright light. The manufacturer states, "Store product in the shipper or store on covered shelves or in closed cabinet prior to use."</p> <p>3. At 11:06 AM on 8/18/2015, staff member #49 (Storeroom Clerk) indicated that the lids of the boxes were only cut off to prevent the product from the exposure to light; however, he/she never thought of how the box tops missing did</p>		<p>provided education to all Supply Chain staff on 9/23/2015 via email and written material. Staff was instructed to leave box lids over enteral tube-feeding supplements intact to prevent exposure to sunlight. The new process was implemented immediately. See Attachment D.</p> <p><u>Compliance Monitoring:</u> Regulatory Survey Coordinator will perform weekly random walk-through observations of Supply chain storage area to ensure compliance with education for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p><u>Implementation Date:</u> 9/23/2015</p> <p><u>Responsible Person(s):</u> Director of Supply Chain</p>		

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S 0612 Bldg. 00	<p>not prevent light exposure to the bottles. The staff member confirmed the product was light sensitive.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</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>(xi) A program of linen management for personnel involved in linen handling. Based on observation, documentation review, and staff interview, the hospital failed to ensure the uncovered assorted linen stored in the hospital's main clean linen storage room was stored in a clean and sanitary environment.</p> <p>Findings included:</p>	S 0612	<p><u>Discussion:</u> The hospital failed to ensure the uncovered assorted linen stored in the hospital's main clean linen storage room was stored in a clean and sanitary environment.</p> <p><u>Corrective Action:</u> Linen was immediately covered and placed out of the path of the duct</p>	10/06/2015	

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	<p>1. At 11:45 AM on 8/18/2015, the EVS (environmental services) clean linen storage room was inspected. The room consisted of wire shelving units and the assorted linen supplies were not covered or protected from environmental contamination. Above the storage racks was HVAC duct work. The duct work below the ceiling surface was observed with accumulation of dust built-up on them and on the vent covers. The vent openings from the duct work were also blowing inward in the room directly above the assorted uncovered linen.</p> <p>2. Terre Haute Regional Hospital Linen Guidelines for Infection Control policy ADM.INF.010 (last reviewed 2/2013) indicated procedures to follow to ensure safe and proper handling of clean linen. Clean linen should be handled with clean hands and kept away from surfaces to prevent contamination.</p> <p>3. At 11:48 AM on 8/18/2015, staff member #39 (Environmental Service Director) confirmed the air movement from the vents on the duct work was blowing dust and lint on to the assorted uncovered linen directly underneath the vent openings.</p>		<p>airflow on 8/18/2015 by the Director of EVS.</p> <p>Policy, "Linen Guidelines for Infection Control", ADM.INF.010 was reviewed by EVS Director on September 15, 2015 and no revisions were necessary. The policy states "Clean linen will be taken to unit by laundry personnel on covered cart. Cart shall remain covered at all times when on a unit". See Attachment E.</p> <p>EVS staff were re-educated by Director of EVS via email with read receipt on October 6, 2015 regarding Policy: ADM.INF.006 and were informed to keep all clean linen covered continuously. See Attachment F. This education will re-enforce the requirements for infection prevention and control related to clean patient linens.</p> <p><u>Compliance Monitoring:</u> Regulatory Survey Coordinator will perform weekly random walk-through observations of clean linen storage area to ensure compliance with education for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p><u>Implementation Date:</u> 10/6/2015</p> <p><u>Responsible Person(s):</u> Director of Environmental Services</p>	

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S 0952 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6).</p> <p>Based on document review and staff interview, the hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for two of twenty patients.</p> <p>Finding(s) include: 1. The policy, "Blood and Blood Derivatives, Requisition, Administration and Transfusion Reactions of, IPC.LAB.006", Reviewed 12/2012, read: "15 Minute Vitals. Fifteen to 20 minutes after the blood/blood</p>	S 0952	<p><u>Discussion:</u> The hospital failed to administer blood transfusions in accordance with approved medical staff policies and procedure for two of twenty patients. In review of two patients receiving four blood units, two of these received-units did not have complete documentation, per policy, on the Blood Bank Inquiry Record form.</p> <p><u>Corrective Action:</u> (a) Policy, IPC.LAB.006, "Blood and Blood Derivatives, Requisition, Administration and Transfusion Reactions "was reviewed by Lab Director on August 18, 2015 and no revisions were necessary. The policy states "15 Minute Vitals: Fifteen to 20 minutes after the blood/blood derivative reaches the patient, but</p>	10/05/2015
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	<p>derivative reaches the patient, but no earlier than 15 minutes or later than 20 minutes.</p> <p>A single unit blood must be transfused within four (4) hours from the time it was issued in the Blood Bank."</p> <p>2. In review of two patients receiving four blood units, two of these received-units did not have complete documentation, per policy, on the Blood Bank Unit Inquiry Record form:</p> <p>Patient #1 --Unit #3b was issued at 5:55 on 8/13/15, started at 6:11 a.m. and ended at 10:00 a.m., was administered for 4 hours and 5 minutes in lieu of within 4 hours.</p> <p>Patient #16 --Unit #3a was started on 7/22/15 at 11:11 a.m. : The 15 minute vitals were documented at 11:35 a.m. which was 14 minutes in lieu of 15 minutes.</p>		<p>no earlier than 15 minutes or later than 20 minutes. A single unit blood must be transfused within four (4) hours from the time it was issued in the Blood Bank. See Attachment G. Patient #1: Blood administration was documented for 4 hours and 5 minutes in lieu of within 4 hours. Patient #16: 15 Minute Vitals were documented at 14 minutes.</p> <p>(b) Lab staff was re-educated by Director of lab Services on October 2, 2015 regarding Policy: IPC.LAB.006 and were informed to carefully look at documentation when reviewing blood slips. All slips with incomplete documentation will need to have an Occurrence Report generated. See attachment H.</p> <p>(c)Nursing staff was also provided with education via email and department flyers on 10/5/2015 by the Regulatory Survey Coordinator. See attachment I. This education will re-enforce the requirements for blood administration documentation.</p> <p><u>Compliance Monitoring:</u> At least 20 blood slips will randomly be reviewed by two lab techs monthly for a period of at least 3 months with oversight by the Blood Bank Technical Coordinator to ensure that documentation not meeting criteria is reported as an occurrence. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p>	

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S 1014 Bldg. 00	<p>3. On 8/18/15 at 10:50 a.m., staff member #1 acknowledged that the above-listed patients had received blood without benefit of complete documentation, per policy, as required.</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, interview, and policy and procedure review, the facility failed to ensure staff followed its pharmacy policy regarding multidose medications.</p> <p>Findings included:</p> <p>1. During the tour of the Behavioral Health Unit at 10:50 AM on 08/18/15, accompanied by staff members #3, the Quality Resources Manager, #7, the Director of Critical Care, and #34, the Unit Manager, one of two open multidose vials of Humalog insulin was observed</p>	S 1014	<p><u>Implementation Date:</u> 10/5/2015</p> <p><u>Responsible Person(s)</u> Director of Laboratory Services and Chief Nursing Officer</p> <p>Discussion: The facility failed to ensure staff followed its Pharmacy policy regarding multidose medications. <u>Corrective Action:</u> (a) Policy, IPC.MED.014, "Medication Management and ordering Processes "was reviewed by Director of Pharmacy on October 1, 2015. Revisions were made. The revised policy states "All vials that contain a preservative or state on the label "Multiple-Use Vial" may be used for 28 days after the vial is opened unless the vial appears to be contaminated, is suspected of contamination, or the manufacturer's literature</p>	10/01/2015
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	<p>without any date marking in the medication cart. Another open multidose vial of medication, Fluphenazine Decanoate, was date marked 8/17 and in the medication cart. The date was not designated as an open or expiration date.</p> <p>2. At 11:00 AM on 08/18/15, staff member #36, an LPN (Licensed Practical Nurse) on the Behavioral Health Unit, indicated pharmacy date marked the multidose medications, but he/she dated the vials when he/she opened them.</p> <p>3. At 11:35 AM on 08/18/15, staff member #37, the Nurse Manager of 4 East, indicated he/she was unsure of the date marking practice of multidose vials, but thought pharmacy dated them when opened.</p> <p>4. The facility policy "Medication Management and Ordering Processes", last revised 04/2015, indicated, "9. Multiple-Dose Vials: A. All vials that contain a preservative or state on the label 'Multiple-Use Vial' may be used for 28 days after the vial is opened unless the vial appears to be contaminated, is suspected of contamination, or the manufacturer's literature indicate specific disposal guidelines after the vial has been opened. ... C. Insulin vials receive special consideration. ... 2. Insulin vials</p>		<p>indicate specific disposal guidelines after the vial has been opened....Vials of insulin are to be disposed of appropriately if medication is still present beyond the 28 day expiration date". See Attachment J. (b)Pharmacy staff were re-educated by Director of Pharmacy via Healthstream Learning assignment issued on 10/1/ 2015 regarding Policy: IPC.MED.014 and were informed to mark each vial of insulin with a date 28 days from pharmacy issue. See Attachment K. (c) Nursing staff were also provided with education via monthly nursing education on 10/1/2015 by the director of Education. Behavioral Health staff were educated by the Manger of Behavioral Health Unit on 9/10/2015. This education will re-enforce the requirements for documentation of discard dates on multi-dose vials. See attachment L. <u>Compliance Monitoring</u>: Director of Pharmacy (or designee) will perform weekly random walk-through observations of hospital medication storage units and Pyxis machines twice monthly for three months to ensure compliance with education and proper documentation of expiration dating of multiple-dose vials. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See</p>	

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S 1118 Bldg. 00	<p>are dated with a 28-day expiration date when they are removed from the Pharmacy refrigerator and sent to the nursing unit. ... D. Open vials must be initialed and dated with the new 28-day expiration date when opened."</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 document review, observation and staff interview, the hospital failed to maintain the Maintenance Shop and equipment in such a manner that the safety and well-being of visitors and/or staff was assured and failed to ensure a safe environment for patients regarding the use of the hydrocollator and warmed fluids.</p> <p>Findings included:</p> <p>1. Terre Haute Regional Hospital 2015 Safety Management Plan indicated the</p>	S 1118	<p>Attachment B. <u>Implementation Date</u>: 10/1/2015 <u>Responsible Person(s)</u> Director of Pharmacy and Director of Behavioral Health Unit</p> <p><u>Discussion</u>:</p> <p>The hospital failed to maintain the Maintenance Shop and equipment in such a manner that the safety and well-being of visitors and/or staff was assured and failed to ensure a safe environment for patients regarding the use of the hydrocollator and warmed fluids.</p> <p><u>Corrective Action</u>:</p> <p>(a)The Maintenance Shop was immediately cleared of clutter, trash and debris on 8/18/2015 by the Director of Plant Operations. All wood working operations were moved to an outside facilities</p>	10/06/2015	

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	<p>process that supports the hospital's mission and vision statements by providing a safe, comfortable, dignified, positive and private environment for patients and visitors as well as a safe work environment for employees, volunteers and medical staff.</p> <p>2. At 10:55 AM on 8/18/2015, the outside Maintenance Shop was inspected. The shop was very unorganized and messy. The table saw had evidence of saw dust and wood chips on it after being used. The clutter in the room presented a trip hazard for staff. The clutter surrounded the table saw for uneasy access to use. There was heavy accumulation of saw dust, dirt, trash, and other debris covering the entire Maintenance Shop floor surface. In the room was an inner room made of chain link material. The door and ceiling were also constructed of chain link material with a cross bar to help support the chain link ceiling of the inner chain link room. The chain link ceiling had assorted maintenance supplies on it. The chain link cross-bar was bending inward into the chain link room. The room did not give a weight limit capacity. The chain link room presented a safety hazard of falling into the middle of the inner chain link room.</p>		<p>services workshop by direction of the Director of Plant Operations on 8/19/2015. The Chain link material was removed and workshop reorganized on 8/19/15 by direction of the Director of Plant Operations.</p> <p>(b) Policy "Infection Control Guidelines in Physical and Occupational Therapies and Speech-Language Pathology", THER.001 was reviewed on 8/25/2015 by the Director of Rehabilitation Services and no revisions were made. Inpatient Rehab staff were educated on importance and requirements for daily temperature monitoring by lead therapist on 9/30/2015. See attachment M. Temperature log for the hydrocollator will now be checked by the therapist managing the 3 hour compliance book for the month on the Inpatient Rehab Unit.</p> <p>(c) A work order to repair the external temperature monitor for the blanket/fluid warmer was placed on 7/29/2015 by the Director of Surgical Services. Staff from Plant Operations examined the warmer and confirmed that the internal thermometer being used to log temperatures was accurately monitoring temperatures within the warmer and that the warmer was warming appropriately. Staff are monitoring temperatures based on internal thermometer. See Attachment N. Repair of the external thermometer on this fluid/blanket warmer was disabled</p>	

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	<p>3. At 10:58 AM on 8/18/2015, staff member #48 (Maintenance Staff) indicated the room was constructed for high theft items. The chain link ceiling of the room was probably not designed to hold supplies. The staff member indicated none of the maintenance staff want to take ownership of the room. The staff member confirmed the Maintenance Shop was extremely messy and needs to be straightened and cleaned up.</p> <p>4. At 9:30 AM on 8/19/2015, staff member #12 (Director of Support Services) confirmed the Maintenance Shop was very messy and had a lot of safety concerns.</p> <p>5. During the tour of the inpatient Rehab Unit at 10:20 AM on 08/18/15, accompanied by staff members #2, the Chief Nursing Officer, #7, the Director of Critical Care, and #30, the Unit Director, a hydrocollator was observed in the therapy room. The Temperature Monitoring Logs for July and August 2015 were observed with no daily documentation of temperature checks.</p> <p>6. At 10:30 AM on 08/18/15, staff member #31, the therapist in the room, indicated he/she was just helping out and normally didn't work on that unit. He/she used the thermometer and showed how to</p>		<p>on 10/6/2015 due to the machine being at end of life and staff are directed via signage on the machine to use internal thermometer for accurate monitoring</p> <p>(d) On 9/16/2015, Director of Surgical Services and Director of Pharmacy received a letter from Hospira, Inc. to clarify the correct temperatures to which irrigation fluids can be warmed. See Attachment O. Policy, "Warming of Irrigation Fluids, IPC.MED.028" was reviewed by Director of Pharmacy and Director of Surgical Services on September 28, 2015 and the revisions were made. The policy now states "Warming cabinet temperatures may not exceed 104° Fahrenheit (F), except for specific clinical situations (i.e. Transurethral Resection of the Prostate (TURP) procedure) in which the irrigation fluid may be warmed to temperatures up to 150° Fahrenheit (F). Irrigation fluid bags will be labeled with a 24-hour expiration date written on the over-wrap for fluids being warmed higher than 104° F, and up to 150° F. If not used prior to the 24-hour expiration fluids warmed 105°F to 150°F must be discarded via sewerage". See Attachment P. OR staff were educated by the Director of Surgical Services on 9/25/2015 regarding Policy: "Warming of Irrigation Fluids, IPC.MED.028" and were informed to notify Plant Operations if fluid warmer temperatures were out of</p>	

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	<p>check the temperature, but indicated he/she had not checked or recorded it on the log.</p> <p>7. At 10:35 AM on 08/18/15, staff member #32, the lead therapist was called and indicated he/she thought the temperatures were checked and recorded daily, but confirmed that could not be determined from the logs. Staff member #30, the Unit Director, also confirmed the temperatures were not documented.</p> <p>8. The facility policy "Infection Control Guidelines in Physical and Occupational Therapies and Speech-Language Pathology", last revised 04/2013, indicated, "2. Hydrocollator (Hot pack warmer): ... C. Temperature of the water will be monitored daily and documented on the temperature log."</p> <p>9. During the tour of the Surgical Department at 10:10 AM on 08/19/15, accompanied by staff members #2, the Chief Nursing Officer, #7, the Director of Critical Care, and #49, the Department Manager, a warming unit was observed in the substerile area with irrigation fluids in the top cabinet and blankets in the bottom cabinet. The temperature display on the unit indicated 118 degrees F. (Fahrenheit) for the top and 128 degrees F. for the bottom. The Temperature Monitoring</p>		<p>range. See Attachment Q. This education will re-enforce the requirements for documentation of appropriate temperatures in fluid warmers and proper date marking of fluids for irrigation.</p> <p><u>Compliance Monitoring:</u> (a) Regulatory Survey Coordinator will perform weekly random walk-through observations of maintenance shop area to ensure compliance with education for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. (b) 100% of hydrocollator temperature log entries will be monitored by the Director of Rehabilitation Services to ensure compliance with education for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. (c) 20 fluid/blanket warmer temperature log entries from warmer in sub-sterile area will be randomly reviewed by Director of Surgical Services or designee monthly for a period of at least 3 months to ensure that irrigation warming log documentation correlates with actual temperature and warming cabinet is within</p>	

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	<p>Log with the unit indicated documentation of 104 degrees F. each day. The irrigation fluids in the unit were date marked with a 14-day expiration date.</p> <p>10. At 10:15 AM on 08/19/15, staff member #50, an orderly who recorded the temperatures, indicated the temperature display for the top unit had not been working for a while and he/she thought a work request had been submitted. He/she indicated he/she used a thermometer placed in the unit to monitor the temperature and it registered 104 degrees F.</p> <p>11. At 10:50 AM on 08/19/15, another warming unit was observed in the hallway by OR (Operating Room) #9 with four 3000 ml. (milliliter) bags of Normal Saline irrigation fluid in the top cabinet and blankets in the bottom cabinet. The Temperature Monitoring Logs indicated both units registered 120 degrees F. daily. The irrigation fluids in the unit were not date marked.</p> <p>12. The facility policy "Warming of Irrigation Fluids", last reviewed 03/2015, indicated, "1. The warming cabinet temperatures must be monitored and recorded daily. A. Warming cabinet temperatures may not exceed 104 degrees</p>		<p>acceptable temperature range. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. (d) 20 fluid/blanket warmer temperature log entries from warmer near OR #9 will be randomly reviewed by Director of Surgical Services or designee monthly for a period of at least 3 months to ensure that irrigation warming log documentation correlates with actual temperature, warming cabinet is within acceptable temperature range, and fluids in warmer are appropriately date marked. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p><u>Implementation Date:</u> 10/6/2015</p> <p><u>Responsible Person(s)</u> Director of Plant Operations, Director of Rehabilitation Services, and Director of Surgical Services</p>		

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S 1162 Bldg. 00	<p>Fahrenheit (F). If this occurs the fluids stored in them will be disposed of and not used for any patient. B. Malfunctioning equipment and equipment unable to maintain consistent temperature control will be reported to Engineering. 2. Fluids stored in the warming cabinet will be identified with a sticker affixed to the outside of the fluid overpouch or bottle. The following information will be documented on the sticker: A. A red lockout tag will be placed around the neck of the fluid bottles with a 14-day expiration date written on a label affixed to the tag."</p> <p>13. At 2:00 PM on 08/19/15, staff member #48, a maintenance staff member, provided a work order for the warmer from 07/29/15 that indicated the unit was making an unusual sound and smelled overheated. Staff member #48 indicated the fan was cleaned, then the unit worked, and that was the only work order for the unit.</p> <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</p>			

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	<p>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 observation and document review, the hospital failed to comply with manufacturer recommendations for the Hydrocollator located in the off site Outpatient Rehab Services facility.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 10:32 AM on 8/18/2015, a Chattanooga Hydrocollator M-4 was observed with a thermometer registering 170 degrees Fahrenheit. The Operation Manual instructions for the use and operation for Outpatient Rehab Service's Hydrocollator M-4 Master Heating Units notes the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 166 degrees Fahrenheit. The off site Outpatient Rehab Service Hydrocollator M-4 Master Heating Unit August 2015 temperature log revealed the water exceeded 166 degrees Fahrenheit 	S 1162	<p><u>Discussion:</u> The hospital failed to comply with manufacturer recommendations for the Hydrocollator located in the off-site Outpatient Rehab Services facility.</p> <p><u>Corrective Action:</u> The Director of Rehab Services reviewed the Operation Manual instructions for the use and operation for Outpatient Rehab Service's Hydrocollator M-4 Master Heating Unit on 8/18/2015 and noted that the recommended operating temperature was 160 to 166 degrees Fahrenheit. The unit temperature control was immediately adjusted to lower the hydrocollator temperature. Outpatient Rehab staff were educated on importance and requirements for daily temperature monitoring and maintaining temperature below 166 degrees Fahrenheit by Director of Rehab Services on 9/30/2015. See Attachment R. A new hydrocollator temp log was developed and implemented by Outpatient Rehab Office Manager on 9/20/15 and</p>	10/01/2015

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S 1164 Bldg. 00	<p>for 12 of 12 days. The Daily Temperature Log noted at the top of the form, the Hydrocollator's temperature should be between 160 and 175 degrees Fahrenheit.</p> <p>4. At 11:00 AM on 8/19/2015, staff member #5 (Quality Manager) confirmed the manufacturer's temperature recommendation for the M-4 Hydrocollator was 160 to 166 degrees Fahrenheit. The staff member confirmed the offsite rehab facility was not using the same Hydrocollator temperature log.</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</p>		<p>implemented on 10/1/2015. If the temperature falls out of range, adjustments are made and the new temp is recorded in the comments. See attachment S.</p> <p><u>Compliance Monitoring:</u> 100% of hydrocollator temperature log entries in Outpatient Rehab area will be monitored by the Director of Rehabilitation Services to ensure compliance with education, that hydrocollator temperatures remain between 160- 166 degrees, and that any temperatures out of range are addressed immediately for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p><u>Implementation Date:</u> 10/1/2015</p> <p><u>Responsible Person(s):</u> Director of Rehabilitation Services</p>		

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	<p>equipment.</p> <p>Based on document review, observation and staff interview, the hospital failed to assure preventive maintenance was conducted on the offsite Outpatient Rehab service's therapy steps and the Rehab in-patient unit's therapy steps.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Terre Haute Regional Hospital Equipment Preventive Maintenance Guidelines policy EOC.ENG.003 (last revised 1/2014) indicated all equipment used in patient care shall have preventive maintenance performed on it. 2. At 10:20 AM on 8/18/2015, the dayroom in the Rehab in-patient unit was toured with staff member #30 (Director of Rehab Unit). The wooden rehab steps for therapy was observed with the left hand rail loose giving the impression of the hand rail to break. The right hand rail was also loose. The wooden steps were visually worn in appearance. The steps had an asset tag; however, there was no preventive maintenance inspection tag on the therapy steps. 3. At 10:25 on 8/18/2015, the offsite Outpatient Rehab services was toured with staff member #41 (OP Therapy Supervisor) and staff member #42 (OP 	S 1164	<p><u>Discussion:</u></p> <p>The hospital failed to assure preventive maintenance was conducted on the offsite Outpatient Rehab service's therapy steps and the Rehab In-patient unit's therapy steps.</p> <p><u>Corrective Action:</u></p> <p>The Director of Rehab Services notified Plant Operation's staff immediately on 8/18/2015 to make needed repairs to both sets of stairs. Left hand rail on the stairs in Inpatient Rehab unit was tightened and chained wire was removed from the stairs in the Outpatient Rehab unit on 8/18/2015. Director of Plant Operations notified in house Biomedical Company of need to place both sets of stairs on hospital preventative maintenance schedule. Annual Preventative Maintenance was performed on 10/6/2015 and will be placed on an annual schedule. See Attachment T.</p> <p><u>Compliance Monitoring:</u></p> <p>Regulatory Survey Coordinator will perform weekly random walk-through observations of therapy stairs in both Inpatient and Outpatient Rehab areas to ensure stairs remain safe without loose bolts, trip hazards, or other safety risks for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and</p>	10/06/2015

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S 1172 Bldg. 00	<p>Therapy PTA). The rehab service was observed with therapy rehab steps which had an access tag; however, there was no preventive maintenance sticker on it. The therapy steps were observed with a chained wire poking through a wooden slat above the lower step that could cause a trip hazard.</p> <p>4. At 10:29 AM on 8/18/2015, staff member #41 (OP Therapy Supervisor) and staff member #42 (OP Therapy PTA) did not have an idea what the rod sticking above the step was for. Neither staff member remembers when the last time the therapy steps were checked by clinical engineering.</p> <p>5. At 12:25 PM on 8/19/2015, staff member #23 (Bio-med Engineer) confirmed the therapy steps located in the offsite Outpatient Rehab services and the Rehab in-patient units were never scheduled to have a preventive maintenance inspection performed on them. The staff member confirmed that the Engineering Department has never inspected the two therapy steps either.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p>		<p>the Board of Trustees monthly times three months. See Attachment B. <u>Implementation Date:</u> 10/6/2015</p> <p>- <u>Responsible Person(s)</u> Director of Plant Operations</p>				

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	<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 document review, observation and interview, the facility failed to ensure environmental services were provided in all areas in a manner that ensured the prevention of transmission of disease or cross-infection to staff and patients</p> <p>Findings included:</p> <p>1. The facility policy "Routine Cleanup of Operative Areas", last reviewed 01/2015, indicated, "2. In the main operating room, the operating room department manager/director is responsible for cleaning of the OR [Operating Room], making cleaning assignments, maintaining cleaning logs, and reporting cleaning to environmental services. ... C. After each surgical procedure: 1. A safe, clean environment</p>	S 1172	<p><u>Discussion:</u> The facility failed to ensure environmental services were provided in all areas in a manner that ensured the prevention of transmission of disease or cross-infection to staff and patients due to findings of food debris and dirt on appliances in Inpatient Rehab Unit, Dust on window ledges in Behavioral Health Unit, and trash items left inside sinks and trash cans in clean procedure rooms in OR and OB.</p> <p><u>Corrective Action:</u> (a) Policy Reh.078, "Meal Preparation, Clean-up, Use of Dishwasher in Activities in ADL Kitchen" was reviewed on 10/2/2015 by the Director of Rehabilitation Services and revised to include the cleaning of the microwave and toaster oven after</p>	10/06/2015

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	<p>should be re-established. ... b. Dispose of items with gross contamination of blood in red bags as infectious waste. Place all non-infectious trash in white bags for disposal. ... e. All receptacle bins, kick buckets and trash receptacles are wiped clean."</p> <p>2. During the tour of the Rehab Unit on 08/18/15 at 10:20 AM, accompanied by staff members #2, the Chief Nursing Officer, #7, the Director of Clinical Care, and #30, the Unit Director, the grill and the microwave in the patient day room were observed sticky and soiled with food debris. The washer and drier and cabinet with supplies were also observed dusty and dirty.</p> <p>3. At 10:20 AM on 08/18/15, staff member #30 indicated staff cleaned the grill and microwave each night, but he/she did not have any documentation of this cleaning schedule.</p> <p>4. During the tour of the Behavioral Health Unit on 08/18/15 at 10:50 AM, accompanied by staff members #3, the Quality Resources Manager, #7, and #34, the Unit Manager, the ledges and suction equipment in the medication room were observed with a heavy layer of dust.</p> <p>5. At 11:25 AM on 08/18/15, staff</p>		<p>usage. In addition, a daily cleaning log was revised to include the daily inspection and cleaning of the microwave and toaster oven when soiled. See Attachment U. Education was sent out via email to Nursing and Occupational Therapy staff on Inpatient Rehab Unit via Director of Rehabilitative Services on 10/2/2015 with read receipt to validate reading and understanding of the information. This education will re-enforce the requirements for proper cleaning of appliances in the Rehab Unit. See Attachment V. (b) Policy," Cleaning Procedures for Nursing Units and Clinical Areas, EVS.009 was reviewed by EVS Director on September 15, 2015 and no revisions were necessary. The policy states "The EVS employee performs a variety of duties related to the department as requested. Damp dust high to low: tops of doors, furniture, lamps, window sills, wall plates, card holders, telephones, etc." See Attachment W. EVS staff were re-educated by Director of EVS via email with read receipt on October 6, 2015 regarding Policy: EVS.009 and were informed to dust all surfaces, including window sills and fixtures. See Attachment X. This education will re-enforce the requirements for infection prevention and control related to dusting in nursing units and clinical areas. (c) Policy EVS.010, Routine Cleanup of Operative Areas was reviewed by</p>	

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	<p>member #35, the environmental services staff member on the unit, indicated he/she usually just had to check the vents and mop the floor in the medication room.</p> <p>6. During the tour of the Surgical Department on 08/19/15 at 10:10 AM, accompanied by staff members #2, #7, and #49, the Surgery Manager, the following observations were made:</p> <p>A. In the open heart room, OR #1, a bag of trash was observed on the side of the medication cart. Two empty plastic IV/irrigation bags were observed hanging on the faucets in the attached alcove room. The room appeared clean and ready for use.</p> <p>B. In the trauma OR, two large red trash bags were observed half full of waste. The room appeared clean and ready for use.</p> <p>7. At 10:30 AM on 08/19/15, staff member #49 confirmed the rooms had not been used today and should have been completely cleaned yesterday.</p> <p>8. During the tour of the Obstetrical Unit on 08/19/15 at 1:10 PM, accompanied by staff members #2, #7, and #51, the Unit Director, Room #2, a clean and patient-ready room, was observed with trash and linen in the soiled containers in</p>		<p>the Director of Surgical Services on 9/25/2015 and no revisions were necessary. Education on policy and proper maintenance of clean operating rooms was presented on 9/25/2015 by the Director and Manager of Surgical Services. See Attachment Y.</p> <p>(d) Policy EVS.010, Routine Cleanup of Operative areas was reviewed by the Director of Women's and Children's Services on 9/15/2015 and no revisions were necessary. The policy states under procedures that all receptacle bins, trash receptacles are to be wiped down and bags are to be replaced after each delivery. Education was completed by the staff and information was posted for staff acknowledgement on 10/5/2015. The trash cans will now be taped across so that no trash will be placed in them after a room turn-over. See attachment Z.</p> <p><u>Compliance Monitoring:</u></p> <p>(a) Regulatory Survey Coordinator will perform weekly random walk-through observations of appliances in Rehab Unit to ensure compliance with education and cleanliness for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p>(b) Regulatory Survey Coordinator will perform weekly random walk-through observations of clinical</p>	

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	the room.		<p>areas on Behavioral Health Unit to ensure compliance with education and cleanliness for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p>(c) Regulatory Survey Coordinator will perform weekly random walk-through observations of operative areas in Surgery to ensure compliance with education and cleanliness for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p>(d) Regulatory Survey Coordinator will perform weekly random walk-through observations of operative areas in Obstetrics to ensure compliance with education and cleanliness for a period of at least 3 months. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B.</p> <p><u>Implementation Date:</u> 10/6/2015</p> <p><u>Responsible Person(s)</u> Director of Environmental Services, Director of Rehabilitation Services, and Director of Surgical Services, and Director of Women and Children's Services.</p>		

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S 1186 Bldg. 00	<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 documentation review and staff interview, the hospital failed to conduct fire drills as per policy for the two off site locations.</p> <p>Findings included:</p> <p>1. Terre Haute Regional Hospital Code Red, Fire Alarms and Fire Drills policy #ADM.EMD,006 (last reviewed 12/2013) indicated fire drills at Off-Premise Facilities shall conduct fire</p>	S 1186	<p><u>Discussion:</u> The hospital failed to conduct fire drills as per policy for the two off site locations. <u>Corrective Action:</u> Policy ADM.EMD.006," Code red, Fire Alarms, and Fire Drills" was reviewed by Director of Plant Operations on 9/15/2015 and no revisions were needed. Director of Plant Operations in coordination with Security Manager, Director of Outpatient Rehab unit, and Director of Radiology, has established a quarterly fire drill in the PDI</p>	10/01/2015

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	<p>drills quarterly. The results of each fire drill will be sent to the Engineering Department upon completion of the fire drill.</p> <p>2. Outpatient Therapy off site conducted quarterly fire drills: 8/14/14; 10/28/14; 1/8/15; and 4/21/15. The Premiere Diagnostic Imaging (PDI) off site 1 fire drill in the last 6 complete quarters. The last documented fire drill was done on 2/17/2014.</p> <p>3. At 10:25 AM on 8/19/2015, staff member #12 (Director of Support Services) indicated the Engineering Dept does not have records of the fire drills the off site locations conducted. The staff member had to contact the off site locations for the documented fire drills. The staff member confirmed the two off sites are not following policy in regard to submitting completed documentation of the fire drills to the Engineering Department and Premiere Diagnostic Imaging off site was not conducting quarterly fire drills as required by hospital policy.</p> <p>4. At 12:30 PM on 8/19/2015, staff member #38 (PDI Supervisor) indicated he/she thought fire drills were only to be conducted annually. The staff member was unaware of the policy requiring off</p>		<p>building to be performed on day 5, every 3 months at 0900 hours. This drill will be performed by the Director of Radiology or designee. Fire drill critique will be completed and forwarded to Director of Plant Operations. Fire Drills in Outpatient Rehab area will follow the same monthly schedule as the main hospital fire drills. This drill will be performed by the Security Manager or designee. Fire drill critique will be completed and forwarded to Director of Plant Operations. See Attachment AA. <u>Compliance Monitoring</u> Regulatory Survey Coordinator will perform audit of 100% of fire drill critiques performed at off-premises buildings monthly for the next three months to ensure compliance with policy and plan of correction. Aggregate data will be submitted to Hospital Leadership, Medical Executive Committee, and the Board of Trustees monthly times three months. See Attachment B. <u>Implementation Date:</u> 10/1/2015 <u>Responsible Person(s)</u> Director of Plant Operations</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	site locations to conduct fire drills quarterly.				