

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2015
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S 0000  Bldg. 00	This visit was for a State hospital licensure survey.  Dates: 05/11/2015 through 05/13/2015  Facility Number: 005005  QA: cjl 06/04/15	S 0000	Hendricks Regional Health acknowledges the state survey	
S 0554  Bldg. 00	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)  (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.  Based on document review, observation and staff interview, the facility failed to ensure the five operating rooms met the required temperature as defined by hospital policy and AORN standards and	S 0554	Correction of Deficiency: Air Conditioning/TemperatureControl – The air handling unit for the operating rooms maintains a constantdischarge temperature from the air handler with local reheat boxes in each ORat the	06/12/2015

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>the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Hendricks Regional Health Environmental Air Handling in OR policy (last reviewed 12/2/2014) indicated the operating room temperatures shall meet the requirements defined by Association of PeriOperative Registered Nurses (AORN).</li> <li>AORN supports the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on temperature and humidity ranges for perioperative settings. The operating rooms temperature range should be between 68 F and 73 F.</li> <li>Hendricks Regional Health hospital's ambulatory surgery center operating room temperature records were reviewed between</li> </ol>		<p>Danville campus, maintain individual temperatures in a range not to exceed 60-72 degree set points. Each operating room has a thermostat and may individually controlled for temperature when necessary to:</p> <ul style="list-style-type: none"> <li>-Meet clinical need or individual procedure necessities, i.e. those involving cement that requires set up to meet manufacturer recommendations or other devices/materials specific to clinical patient conditions such as maintaining dry mesh.</li> <li>-Manage temperature in procedures with high number of associates, surgeons, and anesthesia present.</li> <li>-Meet needs of providers and patients based on control of perspiration in the sterile fields.</li> <li>-Monitor patient vital signs and use blankets from the forced air warming unit to prevent hypothermia.</li> </ul> <p>Expiration dates Immediately all carts were checked for outdated supplies and drugs in the OR, CBC/C-section Suite, SCN, PACU and Anesthesia Carts. Expiration dates of supplies the OR, CBC/ C-Section Suite, SCN, PACU, and Anesthesia carts will be checked monthly by an assigned staff person each month. Documentation of such will be made on a check list and entered into the monthly departmental QA.</p>	

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	<p>4/26/2015 and 5/13/2015. The five operating/procedure rooms average temperature reading was 65 degrees Fahrenheit. All five operating/procedure rooms did not comply with AORN operating room temperature requirements.</p> <p>4. During the tour of the Surgical Department at 12:15 PM on 05/11/15, accompanied by staff members A1, the Chief Nursing Officer, A3, the Policy Coordinator, A13, the Director of Surgery, and A14, the Surgical Clinical Manager, 2 of 2 packages of EKG backpads, with an expiration date of 02/2014, and 1 of 1 packages of electrodes, with an expiration date of 10/2013, were observed in a supply cart in OR (Operating Room) #7.</p> <p>5. During the tour of the decontamination room at 1:00 PM on 05/11/15, accompanied by staff members A1, A3, A13, and A17, the Supervisor of Central Sterile, a container of Cidex test strips were</p>		<p>How will deficiency be prevented in future?</p> <ul style="list-style-type: none"> <li>·Set temperature points in the air handler computer system will be 60-72 degrees.</li> <li>·The OR Director will receive an automatic page if room temperature falls out of the set point temperature range and follow up for correction.</li> <li>·Temperature range in the OR will be part of the OR Departments monthly QA, and will be reviewed quarterly by Quality Steering Committee.</li> <li>·Policy: <b>Environment Air Handling In OR</b>, revised to reflect HRH practice for temperature ranges (Policy Uploaded)</li> </ul> <p>Expired dates QA will be monitored and reported to Quality Steering Committee through monthly QA reports and review</p> <p>Who will be responsible for deficiency correction?</p> <ul style="list-style-type: none"> <li>·The OR Director and Supervisor in Engineering Department for temperature controls</li> <li>·OR Director for policy updates</li> <li>·Departmental Directors for expiration dates QA reporting</li> </ul> <p>When will the deficiency be corrected?</p> <ul style="list-style-type: none"> <li>·OR controls and policy by June 10th, 2013</li> <li>·Expired Dates on materials - Education to staff and QA part of</li> </ul>	

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	<p>observed with a discard date of 04/10/15.</p> <p>6. At 1:15 PM on 05/11/15, staff members A13 and A14 indicated their staff routinely checked and replenished the supplies in all of the carts and storage areas and checks were to be done monthly.</p> <p>7. During the tour of the OR (Operating Room) on the Obstetrical Unit at 1:25 PM on 05/11/15, accompanied by staff members A1, A3, A13, A22, the Night Shift Leader, and A23, the Clinical Manager, the following expired items were observed in the anesthesia cart:</p> <p>A. Two of two size 4 laryngeal masks with an expiration date of 01/28/14</p> <p>B. One of one size 5 laryngeal mask with an expiration date of 10/29/13</p> <p>C. One of five trach cuffs with an expiration date of 02/2013</p> <p>D. Three of eight spinal needles, one expired 09/2014, and two</p>		monthly QA by June 13, 2015	

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	<p>expired 12/2014</p> <p>8. During the tour of the OB (Obstetrical) Surgical corridor at 1:40 PM on 05/11/15, accompanied by staff members A1, A3, A13, A22, and A23, the following expired items were observed in the epidural cart:</p> <p>A. Nine of thirteen spinal needles, one expired 09/2014, one expired 10/2014, and seven expired 12/2014</p> <p>B. Three of six BD Insyte autoguard catheters with an expiration date of 10/2014</p> <p>C. One of two Regional Anesthesia Kits with an expiration date of 12/2014</p> <p>9. At 1:45 PM on 05/11/15, staff member A22 indicated nursing staff performed monthly checks of supplies, but indicated they did not check the epidural cart and he/she did not really know whose responsibility it was to check the cart.</p>			

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	<p>10. During the tour of the PACU (Post Anesthesia Care Unit) at 2:10 PM on 05/11/15, accompanied by staff members A1, A3, A15, the Out-Patient Director, and A16, the Out-Patient Clinical Manager, the following outdated supplies were observed in the supply room:</p> <p>A. One of one 20 gauge autoguard catheter with an expiration date of 10/2014</p> <p>B. Two of five purple top lab tubes with an expiration date of 02/2015</p> <p>C. Four of four green top lab tubes with an expiration date of 10/2014</p> <p>D. One of five red top lab tubes with an expiration date of 02/2015</p> <p>11. At 2:10 PM on 05/11/15, staff members A15 and A16 indicated their staff were to check supplies monthly and remove any outdated items.</p> <p>12. During the tour of the Special Care Nursery at 2:40 PM on 05/11/15, accompanied by staff members A1, A3, A22, and A23,</p>			

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S 0592 Bldg. 00	<p>four of four prewired electrodes, one expired 05/29/14 and three expired 06/05/14, were observed in a cabinet drawer.</p> <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, observation and staff interview, the hospital failed to maintain a clean environment in the clean linen storage/processing and the Materials Handling Department.</p> <p>Findings included:</p>	S 0592	<p>Correction of Deficiency: Beginning 5/12/15 and over the next several days, staff wiped down shelving with wet rags.</p> <p>On 5/13/15, met with laundry staff on cleaning expectations and began regular inspections at end of day. Cleaning and inspections continue each day. Cover all top shelves prior to using air hose.</p> <p>On 5/13/15, met with laundry staff to change process when using air hose including</p>	05/15/2015

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	<p>1. Hendricks Regional Health Safety Management Plan (last reviewed 12/2/2014) indicated each hospital department shall maintain safe work and infection control practices. The hospital laundry/linen processing shall follow local, state, and federal requirements related to a safe, clean, and sanitary environment.</p> <p>2. At 1:55 PM on 5/12/2015, the Materials Management Department was toured. Medical supplies were observed stored on solid gray shelving units. The shelving units were observed caked with dust, dirt, and other debris. The cleaned items that were observed stored on these shelving units included respiratory masks and assorted lab testing tubes.</p> <p>3. At 2:45 PM on 5/12/1015, the clean linen storage and processing room was inspected. The clean room was observed with several shelving units containing folded assorted laundry. The room had at</p>		<p>-Covering linen -spray away from linen -Only use air hose to clean large machines</p> <p>How will deficiency be prevented in future?Storeroom supervisor and Asst. Directorof Support Services will monitor cleanliness of shelves and direct staff toclean as appropriate. Additionally, spot checks will be performed andreported as part of Infection Control rounds. Investigating alternatives tocurrent cleaning process</p> <p>Who will be responsible for deficiency correction?Storeroom supervisor + Infection Control Officer as a part of IC rounds, Asst. Director, Support Services</p> <p>When will the deficiency be corrected?5/15/2015</p>	

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	<p>least 12 of the shelving units that were not protecting the laundry on the shelves from dust, dirt, and other debris that could land on them. Six of the shelves of folded assorted laundry were observed with heavy accumulation of soil residue. The residue was thick that left streaks after passing a finger on the surface of the shelving units. The surface of the industrial equipment within the clean room was observed with thick accumulation of dust, dirt, and other soil residue.</p> <p>4. At 3:00 PM on 5/12/2015, staff member #7 (Assistant Director of Engineering) indicated at the end of the Laundry Department's shift, the staff use a high pressure air hose to blow off the industrial equipment. The dust, dirt, and other soil residue that was blown off the machine would land on other surfaces through out the department. The staff member indicated the department does not have any filtration system that</p>			

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S 0726  Bldg. 00	<p>would eliminate the blown dust from the high pressure air hose.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (c)(7)(A)(B)</p> <p>(c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows:</p> <p>(7) The hospital shall ensure the confidentiality of patient records which includes, but is not limited to, the following:</p> <p>(A) A procedure for releasing information from or copies of records only to authorized individuals in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based on observation and interview, the facility failed to protect patient medical records from unauthorized access in the Immediate Care off-site facility.</p> <p>Findings included:</p> <p>1. During the tour of the off-site Immediate Care facility at 8:40 AM on</p>	S 0726	<p>Correction of Deficiency: Archived medical records located at Avon Immediate Care are stored in a locked file room and are dated 2004-May2008. Since May 2008, the Immediate Care Center has used electronic medical records. The locked file room lock has been changed to the same core lock as the medication lock. The room is</p>	06/15/2015	

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S 1028 Bldg. 00	<p>05/12/15, accompanied by staff members A3, the Policy Coordinator, and A24, the director of the facility, patient medical records were observed stored on open shelves in a locked room.</p> <p>2. At 8:40 AM on 05/12/15, staff member A24 indicated the room was kept locked; however, he/she acknowledged the housekeeping staff had a key to the storage room and cleaned the unit after hours when facility staff was not present.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals</p>		<p>only available to the RegisteredNurse staff. After hours, the key is maintained in the onsite safe. Any support services or cleaning of the room will be completed during hours of operation under supervision. Non-RN staff will not have key access at other times. Please refer to uploaded work order (uploaded documents)</p> <p>How will deficiency be prevented in future? Archived medical Record storage process was changed and implemented effective 6-15-2015 Who will be responsible for deficiency correction? Director ICC When will the deficiency be corrected? Archived medical records located in the locked file room will have the lock core changed to the medicine key. Lock cores and access have been changed effective 6-15-2015. Staff education was completed 6-15-2015, see attached.</p>		

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	<p>are stored and which address, but are not limited to, the following:</p> <p>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. Based on facility document review, observation, and interview, the facility failed to ensure proper medication storage conditions were maintained and storage areas were inspected to prevent the use of outdated medications.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Security of Medication Storage Area", last reviewed 12/02/14, indicated, "All medication storage areas will be either locked or otherwise secured in such a way to prevent access to medications by unauthorized persons; diversion of medications to unintended persons; and to assure that they will be available to patients when needed."</li> <li>The facility policy "Drug Storage Areas- Monthly Inspections", last reviewed 12/02/14, indicated, "1. Drugs shall be stored under the proper conditions of light, temperature, moisture, ventilation, segregation, and security. 2. Each drug storage area shall be locked, and/or under the direct</li> </ol>	S 1028	<p>Correction of Deficiency: Anesthesia cart in CBC (OB) OR will be audited daily to reflect medications are stored properly and that medications are secure. Epidural cart in CBC (OB) Surgical corridor will be checked monthly. The monthly checks will include checking for outdated medications Proper storage of medications in the ICU will be monitored via an audit tool that reflects medications from discharged patients are returned to pharmacy and or sent to the respective unit with patient transfer, medications are not stored with non-medication supplies, and that any open vials are labeled and dated.</p> <p>How will deficiency be prevented in future? This audit will be completed daily; the audit tool will contain the signature of the person completing the audit. The monthly checks will be validated by documentation of date and who completed the checks to a designated form. Proper storage of medications will be added to the ICU quality plan.</p>	07/01/2015

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	<p>supervision of personnel approved to handle the medications at all times. ...4. All medication storage areas shall be inspected by personnel familiar with proper storage requirements at least every month with documentation that the following requirements are met: ...d. Outdated drugs are promptly removed from stock and returned to the pharmacy. ...h. Any drug found improperly stored, outdated, contaminated, and/or visually deteriorated shall be removed and replaced. 5. Monthly medication checks shall include the pharmacy and all areas where medications are stored and will be performed using the drug storage inspection forms."</p> <p>3. During the tour of the OR (Operating Room) on the Obstetrical Unit at 1:25 PM on 05/11/15, accompanied by staff members A1, the COO, Chief Operating Officer, A3, the Policy Coordinator, A13, the Director of Surgery, A22, the Night Shift Leader, and A23, the Clinical Manager, the following medications were observed in a clear plastic pull-down drawer, along with pens, markers, and alcohol swabs, on the top of the anesthesia cart:</p> <p>A. Five vials of Lidocaine 1 1/2% with Epinephrine B. Three vials of Lidocaine 1% C. One vial of Sodium Chloride for</p>		<p>Who will be responsible fordeficiency correction? This audit will be completed the CRNA assigned to CBC forthat day. Monthly epidural cart checks will be completed by anassigned CBC staff member. Clinical manager and or charge nurse in the absence of theclinical manager will complete the audit. When will the deficiency becorrected? Random audits have already been completed. Beginning July 1,2015, daily audits will be done. AfterJuly, the process will be audited monthly and outcomes reported on ICU qualityplan.</p>				

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	<p>injection</p> <p>D. One vial of Epinephrine</p> <p>E. One vial of Bupivacaine</p> <p>The medications were not secured in any way and easily accessible.</p> <p>4. At 1:25 PM on 05/11/15, staff members A1, A3, and A22 confirmed the housekeeping staff cleaned the OR after hours without the unit staff in attendance.</p> <p>5. During the tour of the OB (Obstetrical) Surgical corridor at 1:40 PM on 05/11/15, accompanied by staff members A1, A3, A13, A22, and A23, two vials of Bupivacaine and one vial of Epinephrine, with expiration dates of Jan. 1, 2015, were observed stored in the epidural cart.</p> <p>6. At 1:40 PM on 05/11/15, staff member A22 indicated nursing staff did not check the epidural cart and he/she did not really know whose responsibility it was to check the cart.</p> <p>7. During the tour of the ICU (Intensive Care Unit) at 11:20 AM on 05/12/15, accompanied by staff members A1, A3, and A30, the Director of the unit, a plastic bag with a patient's medication was observed stored in a locked medication cabinet along with some money and a box of chocolates. The</p>			

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S 1118 Bldg. 00	<p>patient was no longer in the ICU. Also, an open, but not dated or labeled, one milliliter vial of Ketoralac Tromethamine was observed in the locked medication drawer for bed 4.</p> <p>8. At 11:25 AM on 05/12/15, staff member A29, the nurse for the patient in bed 4, indicated the medication was not ordered for that patient and he/she did not know why it was in that drawer.</p> <p>9. At 1:00 PM on 05/11/15, staff members A1 and A3 indicated monthly pharmacy checks were performed, but confirmed the medications observed on the tours were not stored appropriately.</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</p>	S 1118	Correction of Deficiency:Interim correction: deficiency withwarming cabinet temperature logs and maximum temperature parameters	06/19/2015			

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	<p>hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured for the off-site radiology/laboratory location the facility failed to ensure a safe environment for patients by following AORN (Association of periOperative Nurses) guidelines regarding warming cabinets.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Hendricks Regional Health Organizational Wide Policy Infection Control Eye Wash Stations policy (last reviewed 12/2/2014) indicated emergency eye wash stations are available should a chemical or blood/body fluid exposure occur.</li> <li>The Sysmex Hematology Analyzer operation's manual indicated the waste exiting the machine through the waste fluid tubing was to be treated as</li> </ol>		<p>identified and corrected to meet current standards in all identified areas during dates of survey (5.11.15 – 5.13.15) and correction plan established.</p> <p>Develop policy pertaining to warming cabinet guidelines within thirty (30) days of survey (6.11.15).</p> <p>Evaluate tracking monitor forms for consistency throughout the organization within sixty (60) days of survey (7.10.15).</p> <p>Proper labeling of cabinets to reflect guidelines on temperatures within sixty (60) days of survey (7.10.15).</p> <p>Education to associates within sixty (60) days of survey (7.10.15).</p> <p>How will deficiency be prevented in future? All areas with fluid and/or blanket warmers will monitor log sheets for completion and compliance for six (6) months.</p> <p>Policy developed within thirty (30) days of identified deficiency with warmers.</p> <p>Log forms will be uniform throughout the nursing clinical areas and stored on shared nursing drive for easy access.</p> <p>Label cabinets with temperature parameters and validate appropriate logs on each unit.</p> <p>Educate associates regarding warming cabinet policy, posted on shared nursing drive.</p> <p>Who will be responsible for deficiency correction? Jennifer Miller, Director of ED; Paula Spoonmore, CNS; along with</p>				

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	<p>hazardous waste.</p> <p>3. At 8:30 am on 5/12/2015, the Avon radiology/laboratory department was observed with the waste fluid tubing of the hematology analyzer on the counter next to the sink exiting into the sink's basin. The sink was also the location of the portable eye wash station. Therefore, the waste from the analyzer presents the possibility of contaminants splashing into someone's eyes if the eye wash station was used immediately.</p> <p>4. At 1:15 PM on 5/12/2015, staff member #11 (Clinical Engineer) confirmed the discharged waste from the hematology analyzer should be treated as hazardous waste. The staff member confirmed the operation's manual identified the waste tube was for excess hazardous waste from the analyzer.</p> <p>5. During the tour of the OR</p>		<p>Director/ClinicalManager of units using fluid and/or blanket warmers. When will the deficiency be corrected?All steps will be complete by 6/19/2015</p>		

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	<p>(Operating Room) on the Obstetrical Unit at 1:25 PM on 05/11/15, accompanied by staff members A1, the COO, Chief Operating Officer, A3, the Policy Coordinator, A13, the Director of Surgery, A22, the Night Shift Leader, and A23, the Clinical Manager, eight 1000 cc. (cubic centimeters) bags of intravenous fluids were observed in the upper cabinet of a warming unit. The bags were dated 4/28, 5/5, 5/6, and 5/8. The logs indicated the unit was to be checked each shift with 104 degrees F. (Fahrenheit) the maximum temperature of the upper cabinet and 130 degrees F. the maximum temperature of the lower cabinet. Out of the 21 checks that should have been done for May so far, 4 were missed, and 8 checks of the upper cabinet were above 104 degrees F.</p> <p>6. At 1:30 PM on 05/11/15, staff member A22 indicated the warming cabinets were supposed to be checked every shift and</p>			

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	<p>indicated the fluids were marked with the date they were placed in the warmer and could remain in the warmer for three days.</p> <p>7. During the tour of the Out-Patient Surgical Unit at 1:55 PM on 05/11/15, accompanied by staff members A1, A3, A14, the Director, and A16, the Clinical Manager, a Steris warmer was observed with an empty upper cabinet registering 110 degrees F. and a lower cabinet containing blankets registering 130 degrees F. The monitoring sheets for both cabinets were identified as "Blanket Warmer Weekly Log", but the maximum temperature was 110 degrees for the upper cabinet and 130 degrees for the lower cabinet. "Do Not Warm Solutions in This Cabinet...Patient Burn Risk" was indicated on both of the forms.</p> <p>8. At 1:55 PM on 05/11/15, staff member A15 indicated fluids could be placed in the upper cabinet and</p>			

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	<p>was unsure about the 110 temperature recommendation.</p> <p>9. During the tour of the off-site surgical center at 9:20 AM on 05/12/15, accompanied by staff members A1, A3, A13, and A25, the Clinical Manager of the center, a Steris blanket warmer was observed with the upper cabinet registering 156 degrees F. and the lower cabinet registering 158 degrees F. The monitoring sheet was identified as "Blanket Warmer Temperature Log" and indicated the maximum temperature should be 130 degrees F., but all of the temperatures recorded were between 153 to 167 degrees F.</p> <p>10. During the tour of the Emergency Department at 10:25 AM on 05/12/15, accompanied by staff members A1, A3, and A26, the Director, a Steris warming unit was observed in the corridor with pediatric gowns in the upper cabinet and blankets in the lower cabinet. Both cabinets registered</p>			

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	<p>120 degrees F., but there were no monitoring logs.</p> <p>11 At 10:35 AM on 05/12/15, staff member A26 confirmed staff monitored the warmer with fluids and blankets, but not the unit containing only linens.. He/she indicated any fluids placed in the warmer were dated with the expiration date.</p> <p>12. During the tour of the Medical Unit at 11:30 AM on 05/12/15, accompanied by staff members A1, A3, and A20, the Director, a warming unit with two cabinets was observed, but only one of the cabinets was monitored. The log indicated the unit was to be monitored weekly, but seven weeks were missed for the year so far. A smaller Olympic warmer containing blankets was observed in the corridor with no monitoring logs.</p> <p>13. At 11:35 AM on 05/12/15, staff member A20 indicated it was</p>			

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	<p>the duty of the unit assistant to monitor the warming units and confirmed the missing documentation.</p> <p>14. At 4:10 PM on 05/12/15, staff members A1 and A3 confirmed the inconsistencies with the temperatures, logs, dating, and monitoring of the warming units. They confirmed the facility did not have a policy for the warming units. They confirmed the facility followed AORN (Association of periOperative Nurses) guidelines which indicated warming temperatures for blankets or other patient linens should not exceed 130 degrees F. The guidelines also indicated solutions, blankets, and patient linens should be stored in separate warming cabinets or in separate compartments with independent temperature controls and temperatures should be set, maintained, monitored, and documented according to organizational policy.</p>			

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S 1186 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT</p> <p>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 facility failed to provide documented fire drills as per hospital policy for six (6) off-site locations.</p> <p>Findings included:</p> <p>1. Hendricks Regional Health Fire</p>	S 1186	<p>Correction of Deficiency: Fire drills at Brownsburg, Avon, Plainfield, YMCA and Hibbeln Surgery Center were completed in 1st quarter, 2015 and will be completed for the second quarter, 2015 by June 30, 2015. The fire drill for the Brownsburg Clinic will be completed by June 30, 2015.</p> <p>How will deficiency be prevented in future?</p>	06/30/2015

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	<p>Emergency Plan - Code Red (last reviewed 12/2/2014) indicated fire drills will be held once a quarter on each shift for all hospital locations.</p> <p>2. The 2014 Hendricks Regional Health fire alarm drill reports were reviewed. Documented fire drills were not provided for Hendricks Regional Health Hibbelin Surgery Center for 2014. Hendricks Regional Health off-site locations: Brownsburg, Avon, Plainfield, YMCA, and Brownsburg Clinic; three quarters of fire drills were missing for these 5 off-site locations.</p> <p>3. At 1:45 PM on 5/12/2015, staff member #6 (Director of Engineering) indicated the staff could not locate any fire drills for Hibbelin surgery center. The staff member confirmed quarterly fire drills have not been conducted at the offsite locations as per hospital policy.</p>		<p>Fire drills will be conducted at these off-site locations consistent with HRH policy in the future.</p> <p>Completion will be reviewed by Asst. Director, Engineering Who will be responsible for deficiency correction? Asst. Director of Engineering When will the deficiency be corrected? Fire drills at these locations have been or will be completed on quarterly schedule by June 30, 2015.</p>		

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

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