

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150082	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
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NAME OF PROVIDER OR SUPPLIER  DEACONESS HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN 47747
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 005074  Survey dates: 9/14/15 to 9/17/15  QA: JL 10/15/15	S 0000		
S 0322  Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)  (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:  (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and staff interview, the governing board failed to ensure the medical staff followed facility policy related to Do Not Resuscitate (DNR) status for 2 of 2 patients (patient #1 and 3).  Findings include;  1. Facility policy titled "DO NOT RESUSCITATE: LIMITING	S 0322	<b>CorrectiveAction to be Taken:</b> There will be Medical Staff Education through theMedical Staff newsletter. <b>Prevention of Future Deficiencies:</b> 1. Monthly audit of all cases in which a DNR order was placed in the medical record, with results reported to the Medical Record Committee.	12/12/2015

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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S 0406 Bldg. 00	<p>LIFE-SUSTAINING TREATMENT WITHDRAWAL OF TREATMENT" last reviewed/revised 12/22/14 states on page 2: "7. After a DNR decision or withdrawal of treatment decision is made, the attending physician will document accordingly in EPIC electronic medical record. The documentation should include: .....b. persons involved in the decision,....."</p> <p>2. Patient #1 was admitted to the facility on 10/8/14. An order was written on 10/13/14 at 0056 hours for DNR terminal wean and withdraw of care. The medical record lacked documentation of the name of person/persons involved in the decision. The patient expired on 10/13/15.</p> <p>3. Patient #3 was admitted to the facility on 3/30/15. An order was written on 4/2/15 at 3:04 p.m. for DNR. The medical record lacked documentation of the name of person/persons involved in the decision. The patient expired on 4/2/15.</p> <p>4. Staff members #30 (Quality Improvement) and #44 (Quality Improvement) verified the medical record information at 12:00 p.m. on 9/17/15.</p> <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</p>		<p>2. MedicalStaff members who do not document appropriately to be notified of the deficiency by the Chairman of the Medical Record Committee.</p> <p><b>Responsible Parties:</b> Medical Record Manager Director of Medical Affairs and Emergency Services Chairman of the Medical Record Committee</p> <p><b>Target Completion Date:</b> Article for the Medical Staff newsletter to be in December, 2015 edition. First audit report to the Medical Record Committee is scheduled for 12/12/2015.</p>	

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	<p>evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the quality assessment and performance improvement (QAPI) program failed to include one off-site service in its review/evaluation (OSB4).</p> <p>Findings:</p> <p>1. Review of the document titled Quality Improvement Plan FY 14/15 quality improvement integrates the efforts of leadership, medical staff, clinical professions and hospital departments in pursuit of the hospital's mission. The Plan was made effective October 1, 2014 to September 30, 2015.</p> <p>2. Review of 2014/2015 documentation of quality reports lacked evidence of reports provided to or reviewed by the program for off-site OSB4.</p> <p>3. On 9/17/15 at 9:00am, A8, Director of Quality, indicated off-site OSB4 did not submit quality activity for review/evaluation to the QAPI committee for FY 2014/2015.</p>	S 0406	<p><b>Plan of Correction: 0406</b> <b>Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies:</b> <b>Responsible Parties: Target Completion Date:</b> 0406: Failure to include one off-site service in our review/evaluation (OSB4). Quality assessment and performance improvement will be implemented at (OSB4). The manager of OSB4 will receive training in the methodology and the Performance Improvement Representative will monitor the activity quarterly providing feedback on the measure selected. A Work Group meets quarterly to review the off-site listing and keep it up to date. This group will notify the Quality department of any changes, a Performance Improvement Representative will be assigned to any new service to begin quality activity and monitor quarterly. Annually, the Quality department will compare the list of Off Site services to the activity recorded and account for each off-site area. Director of Quality. Manager of OSB4 will be trained by 11/30/15. The next Offsite Work Group meeting will take place on 12/28/15. Improvement feedback and</p>	12/31/2015	

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S 0508 Bldg. 00	<p>410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1(b)(1)(A)(B)</p> <p>(b) The food and dietetic service shall have the following:</p> <p>(1) A full-time employee who: (A) serves as director of the food and dietetic services; and (B) is responsible for the daily management of the dietary services.</p> <p>Based on document review, observation, and interview, the food services director failed to ensure food management policies and procedures (P&amp;P) were followed for 2 food types (prepared food and pre-packaged food) in one area (OSA3 wound care).</p> <p>Findings:</p> <p>1. Review of the P&amp;P titled Dating Procedure and Prepared Foods, indicated the following: anytime an item is prepared and put in the refrigerator, write the date and the letter "R" on the item. Also include Prep (P) dates. The food item should be discarded 5 days from preparation date if it is not used. The P&amp;P also indicated Open containers/bags of ready-to-use prepared products will be used by manufacturer expiration date on container. If no manufacturer expiration date on container, will note date opened and date to discard product (which will be 90 days from open date) on container. The P&amp;P was reviewed/revised July 2015.</p> <p>2. On 9/15/15 at 10:00am during tour of off-site</p>	S 0508	<p>monitoring will begin with the quarter ending 12/31/15. New reports are due on 02/15/16.</p> <p><b>CorrectiveAction to be Taken:</b></p> <ol style="list-style-type: none"> <li>1. Develop process to ensure all pre-packaged and prepared foods are date marked.</li> <li>2. Educate Dietetics Staff on the process. <b>See Exhibit A</b></li> <li>3. Inform nursing unit/area staff of the process that Dietetics will be following. <b>See Exhibit B.</b></li> <li>4. Attend Patient Care Tech Council Meeting.</li> </ol> <p><b>Prevention of Future Deficiencies:</b> Compliance with process included in the monthly pantry audits. <b>See Exhibit C</b></p> <p><b>Responsible Parties:</b> Dietetics Manager, Main Campus Dietetics Manager, Gateway Campus  Dietetics Manager, Cross Pointe Campus</p> <p><b>Target Completion Date:</b></p>	12/21/2015

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S 0554 Bldg. 00	<p>OSA3, in the presence of G1, Site Manager, and G5, Physical Medicine Department Coordinator, the following was observed: in the rehabilitation therapy unit was a refrigerator indicated to contain food for speech therapy patients. Inside the refrigerator were 4 prepared fruit cups and 4 prepared pudding cups and 17 pre-packaged cookies. None of the foods were labeled with expiration dates.</p> <p>3. On 9/15/15 at 10:00am G5 indicated the prepared fruit and pudding cups were provided by the hospital kitchen and were not dated because the P&amp;P is to rotate kitchen prepared foods weekly. G5 indicated the cookies were pre-packaged by the manufacturer and came to the unit without expiration dates.</p> <p>4. On 9/17/15 at 11:45am, A5, Operations Manager/Dietary, provided written P&amp;P for food expiration and indicated prepared and pre-packaged foods should be dated.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a)</p> <p>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on documentation review and staff interview, the hospital failed to ensure 10 of 16 operating rooms met the required temperature as defined by hospital policy and Association of PeriOperative Registered Nurses (AORN) guidelines (operating rooms #1,</p>	S 0554	<p>December 21, 2015</p> <p><b>Deficiency:</b></p> <p><b>Corrective Action to be Taken:</b></p> <p><b>Prevention of Future Deficiencies:</b></p> <p><b>Responsible Parties:</b></p>	11/20/2015

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	<p>2, 3, 6, 7, 8, 9, 10a, 11, and 12) and failed to provide a safe and healthful environment in two locations (off-sites OSA3 and OSA9).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Deaconess Health System, Inc Infection Prevention &amp; Control Plan (last reviewed 6/11/2015) references Association of PeriOperative Registered Nurses (AORN) for current and standards of practice guidelines, parameters, and other information specific to infection prevention, surveillance, and control.</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; while, the humidity should be between 30% and 60%.</li> <li>The Engineering Director provided randomly selected temperature and humidity readings for the operating rooms located at Deaconess Hospital. The logs for 8/1/2015 through 8/4/2015 indicated 10 of 16 operating room temperature readings were consistently below 68 degrees Fahrenheit (operating</li> </ol>		<p><b>Target Completion Date:</b></p> <p><b>0554: Infection Control:</b> 10 of 16 operating rooms did not meet the required temperature as defined by hospital policy and AORN guidelines (ORs 1, 2, 3, 6, 7, 8, 9, 10a, 11, 12)</p> <p>Engineering met with Surgery to get a policy written per AORN and AIA guidelines.</p> <p>Monitor OR temperatures in accordance with new policy, Document No. F-18 (attached).</p> <p style="text-align: center;">Manager of Engineering and Maintenance  and  Surgery Manager  11/20/2015</p> <p><b>0554: Infection Control:</b> 2 soiled refrigerators at Gateway Materiel Management without documentation of cleaning (OS3).</p> <p>Refrigerator was thoroughly cleaned on 9/17/15.</p> <p>Routine Cleaning duty assigned to warehouse staff. Refrigerators will</p>	

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	<p>rooms #1, 2, 3, 6, 7, 8, 9, 10a, 11, and 12).</p> <p>4. At 2:45 PM on 9/14/2015, staff member #A45 (Surgery Supervisor) indicated the operating rooms temperature requirements are 68 to 75 degrees Fahrenheit. The staff member indicated they could not locate any policy that specifies the operating room temperature and humidity parameters.</p> <p>5. At 8:30 AM on 9/15/2015, staff member #A10 (Deaconess Hospital Site Manager) provided the AORN Guidelines for operating room temperatures that the range should be between 68 to 75 degrees Fahrenheit. The staff member confirmed the operating rooms did not all meet the required AORN guidelines because the physicians will adjust the temperature lower than 68 degrees Fahrenheit. The physicians will contact the Engineering Department to let staff know that a temperature alarm will sound. The staff member confirmed that at least one operating room consistently read less than 60 degrees Fahrenheit.</p> <p>6. On 9/15/15 at 11:55am, during facility tour of off-site OSA3, in the presence of G1, Site Manager, and G8, Environmental Services Manager, the following was observed: In the warehouse/supply storage area were 2</p>		<p>be cleaned on a weekly basis and date of cleaning will be indicated on the refrigerator/freezer temperature log.</p> <p>Manager of Materiel Management</p> <p>Completed 09/17/2015 with on-going monitoring.</p> <p><b>0554: Infection Control:</b> Inappropriately stored items, including one washing machine containing a dead rodent at OSA9.</p> <p>All items were removed 09/21/2015.</p> <p>The generator area will no longer be used for any storage.</p> <p>Manager of Engineering and Maintenance.</p> <p>Completed 09/21/2015</p>	

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	<p>refrigerators. Inside one refrigerator were no supplies/stock, the other contained 3 medium sized boxes without indication of contents, but labeled to keep refrigerated and 2 packages of urine dip sticks. The interior of both refrigerators was dirty with dust, debris and a few hair like particles. Cleaning policies and documentation of cleaning was requested at that time.</p> <p>7. On 9/15/15 at 11:55am, G8 indicated documentation of cleaning the refrigerators was not available and no further documentation was provided by time of exit.</p> <p>8. On 9/15/15 during facility tour of off-site OSA9, in the presence of CP1, Environment and Maintenance technician, CP2, Environment and Maintenance Coordinator, and CP3, Chief Administrative Officer, the following was observed in the fenced area with the generator: lined along the fence were 5 washing machines, inside one machine was standing water with a dead appearing dark colored rodent floating in the water; on the concrete, beside one of the washers was an automobile type battery; and on the far side of the fence was various stacked pieces of furniture.</p> <p>9. On 9/15/15 at 1:30pm, CP1 indicated the washers and furniture pieces were kept for spare parts and the battery needed to be disposed.</p> <p>10. On 9/15/15 at 1:30pm CP2 and CP3 indicated the items (washers, battery, and furniture) should not be kept in that area and indicated they could pose health/sanitary risks.</p>			

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S 0560 Bldg. 00	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(d)</p> <p>(d) A person qualified by training or experience shall be designated as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases.</p> <p>Based on document review, observation, and interview, the infection control officer failed to ensure implementation of the policy for sanitation of laundry machines and rooms for one laundry machine (C41523867) at off-site OSA9.</p> <p>Findings:</p> <p>1. Review of Policy No. IC.059, titled Housekeeping - Sanitation of Laundry Machines &amp; Rooms, indicated the following: Laundry machines used by patients will be cleaned and sanitized after each use to maintain a hygienic environment and to prevent the spread of infectious disease. 1. Wipes down interior and exterior of all laundry machines used by patients with Clorox wipes. 2. Mops floor of all laundry areas weekly with appropriate cleaner. The policy was reviewed/ revised 4/15.</p> <p>2. On 9/15/15 at 2:15pm, during tour of OSA9, in the presence of CP1, Environment and Maintenance technician, CP2, Environment and Maintenance Coordinator, and CP3, Chief Administrative Officer, the following was observed in the laundry room of a patient care unit was a washing machine identified as</p>	S 0560	<p><b>Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies:</b> <b>Responsible Parties: Target Completion Date:</b> <b>0560: Infection Control:</b> Disinfecting of patient-use washing machines at OSA 9 (Cross Pointe) Major revision in policy and procedure IC.059 for the use of washing machine in patient care area Major revisions in September with education and training of staff on September 28 and September 30, 2015 Implementation of revised policy on October 1. Log developed as part of the policy requiring staff document pertinent information that reflects a laundering quality test was completed according to policy. Manager will monitor log on a weekly basis for 1 month and then monthly thereafter. Nursing Department Manager of Behavioral Services Revisions</p>	10/01/2015

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S 0598 Bldg. 00	<p>C41523867. Evidence of cleaning between patient use was requested.</p> <p>3. On 9/15/15 at 2:15pm, CP3 indicated the washer was used by patients to clean their personal laundry. CP3 indicated documentation of cleaning between use was not maintained.</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on documentation review, observation, and staff interview, the hospital failed to ensure Deaconess Hospital Outpatient Rehab (DPC) was complying with Federal Drug Administration (FDA) requirements on not refilling Ultrasound Gel containers.</p> <p>Findings included:</p> <p>1. FDA Alert and Notification</p>	S 0598	<p>of Policy reviewed with nursing staff at staff meetings, September 28 and 30, 2015. Policy was posted on the units at this time. Policy changes implemented October 1, 2015.</p> <p><b>Deficiency:</b></p> <p><b>Corrective Action to be Taken:</b></p> <p><b>Prevention of Future Deficiencies:</b></p> <p><b>Responsible Parties:</b></p> <p><b>Target Completion Date:</b></p> <p><b>0598: Infection Control</b></p>	11/17/2015

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	<p>documented dated June 8, 2012 indicated ultrasound gels contain parabens or methyl benzoate that inhibit, but not kill, the growth of bacteria. Once a container of sterile or non-sterile ultrasound gel is opened, it is no longer sterile and contamination during ongoing use is possible. Use open containers of ultrasound gel for low risk procedures on intact skin and for low risk patients. Never refill or "top off" containers of ultrasound gel during use. The original container should be used and then discarded. past studies have demonstrated that ultrasound gels do not have antimicrobial properties and could serve as a medium for bacterial growth. Contaminated gels have been found to be the source of other outbreaks of infection in the last two decades.</p> <p>2. At 2:05 PM on 9/15/2015, the DPC Department's ultrasound gel storage area was inspected. The storage area had a half filled bulk gel container with partially filled gel bottles.</p> <p>3. At 2:07 PM on 9/15/2015, staff member #A48, Physical Therapist, indicated the ultrasound gel bottles are refilled with the bulk gallon gel container. The staff member indicated he/she did not realize that ultrasound gel containers are not to be refilled.</p>		<p>Outpatient Rehab at DPC: Ensuring compliance with FDA requirements for not refilling ultrasound gel containers.</p> <p>Deaconess will be removing the ultrasound gel "bulk" container option from their ordering list (Lawson). Staff were instructed on 11/17/2015 that they should only order single-use packets of gel. Staff were informed that they are not to refill any ultrasound gel containers and once a container is opened it should be promptly used then disposed of. Staff were provided with recommendations from the Federal Drug Administration (FDA) on 11/11/2015.</p> <p>Staff were educated via e-mail on 11/17/2015 and 11/11/2015.</p> <p>ProgressiveHealth will follow the requirements and recommendations of the FDA.</p> <p>Deaconess staff will no longer have the option of ordering "bulk" containers of ultrasound gel.</p> <p style="text-align: center;">Director of Inpatient/ Outpatient Therapy</p>	

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S 0612 Bldg. 00	<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.</p> <p>Based on documentation review, observation, and staff interview, the hospital failed to ensure the separation of soiled and clean linen processing within the Special Processing room.</p> <p>Findings included:</p> <p>1. The 2001 American Institute of</p>	S 0612	<p>ProgressiveHealth Compliance Officer</p> <p>Manager of Material Management</p> <p>11/17/2015</p> <p><b>Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies:</b> <b>Responsible Parties: Target Completion Date:</b> <b>0612: Infection Control:</b> Ensure the separation of soiled and clean linen processing within the Special Processing Room. Laundry personnel notified of Policy and Procedure</p>	03/31/2016

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	<p>Architects (AIA) Guidelines at 7.23.D5. indicate the following; Arrangement of equipment that will permit an orderly work flow and minimize cross-traffic that might mix clean and soiled operations.</p> <p>2. Laundry/Linen Department Internal Policy and Procedure #O.P.5.10 (last reviewed March 2015) indicated all clean linens will be stored in covered carts/plastic bags, The clean and soiled linen shall be processed in a manner that prevents the possibility of cross-contamination.</p> <p>3. At 1:25 PM on 9/15/2015, the Special Processing Room that launders small individual articles was toured. The entrance to the room starts with an Industrial dryer and an industrial washer was located to the left side of the dryer. To the left of the industrial washer was a small washer then again to the left was a small dryer. On top of the small dryer was stacks of folded individual stacks of children clothing that were not covered. The location of the two washers and two dryers were positioned in a manner that did not provide a good separation of soiled and clean linen during the processing of the linen. Thus, there was not a clear separation of clean and soiled linen processing.</p>		<p>and staff reeducated on the proper procedure of clean and soiled separation. Policy and Procedure O.P 5-10 The equipment will be reconfigured in the room to prevent cross contamination and to ensure clean and soiled linen is kept separate. Department Manager, Laundry Supervisor, and Regulatory &amp; Accreditation Officer will ensure compliance with O.P.5-10 through observation during routine rounding. Accreditation &amp; Regulatory Officer will require Plans of Correction from Department Manager when non-compliance is observed. Equipment will be reconfigured to ensure compliance. Department Manager and Laundry Supervisor This will need to be implemented in 30 day phases. Receive estimates from the contractors by January 15, 2016. Submit quotation to capital equipment team for approval by January 18, 2016. Work to begin to re-configure the equipment by February 19, 2016. Completion by March 31, 2016</p>		

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S 0912 Bldg. 00	<p>4. At 1:30 PM on 9/15/2015, staff member #A15 (Architect) confirmed AIA guidelines require a good separation of soiled and clean linen. The setup in the Special Processing Room did not meet the AIA guidelines for a clear separation of clean and soiled linen while laundry was processed.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job</p>			

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	<p>descriptions with reporting responsibilities for all nursing staff positions.</p> <p>(iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements.</p> <p>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and interview, the nurse executive failed to ensure pain assessments and reassessments were done according to policy and protocol for 8 of 12 closed medical records reviewed (#N1, N2, N3, N6, N7, N8, N9, and N12), 1 of 5 open patient records reviewed (patient #4), failed to ensure physician orders were followed for prn (as needed) medication for 1 of 3 Intensive Care Unit (ICU) patients (patient #6), failed to ensure fall risk interventions were in place for 1 of 3 ICU patients (patient #6) and failed to ensure policies related to patient privacy were followed for 4 of 4 patients in the Post Anesthesia Care Unit (PACU).</p> <p>Findings included:</p> <p>1. Review of the facility policy "Pain Management", last revised September 15, 2014, indicated, "A. To provide all</p>	S 0912	<p><b>Deficiency:</b></p> <p><b>Corrective Action to be Taken:</b></p> <p><b>Prevention of Future Deficiencies:</b></p> <p><b>Responsible Parties:</b></p> <p><b>Target Completion Date:</b></p> <p><b>0912: Nursing Service:</b></p> <p>a) Pain assessments and reassessments not performed according to policy and protocol for 8 of 12 closed medical records and 1 of 5 open medical records.</p> <p>a) Audit records monthly on each unit to ensure compliance</p> <p>1. Audit minimum of 10 records per month per unit.</p> <p>2. Utilize OFI (Opportunity for</p>	12/20/2015

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	<p>patients with safe, optimal pain management. ... B. The nurse will make an initial assessment of the patient's level of pain that includes severity of pain on an age specific verbal/nonverbal pain scale, location, onset, frequency, duration, quality, aggravating/alleviating factors, contributing psychosocial factors, assessment of site if appropriate, e.g., surgical wound. C. Pain Assessment and Reassessment: ... A measure of pain intensity and a measure of pain relief as reported by the patient will be assessed and documented in EPIC as follows: 1. Upon admission. ... 4. Administration of pain medication. 5. After each pain management intervention, the recommended interval for reassessment is one hour for all interventions. ... 3. Patients who present to the Emergency Department for pain will receive a medical exam to determine their medical condition, and medications are prescribed as necessary. Complaints and symptoms of chronic pain are recommended to be treated with non-narcotic medications."</p> <p>2. Medical record #N1 indicated the patient received intravenous (IV) pain medication at 0842 hours on 03/12/15 for a pain score of 10 (1 to 10 score with 10 being the worst pain), but the record lacked documentation of a reassessment of pain prior to being admitted at 1422</p>		<p>Improvement) form to review areas not meeting standard with individual staff members.</p> <p>3. Implement progressive disciplinary action for recurring violations by individual nursing staff members.</p> <p>a) Work with EPIC and Information Technology (IT) to develop a BPA (Best Practice Alert) to notify nursing staff when pain reassessment has not been documented in identified time frame.</p> <p>This is to be a long-term solution, as building BPAs into EPIC can take months. Until the BPA is built, audits will continue as the primary means of gaining compliance.</p> <p>Once the BPA is built, we will determine whether audits are still needed.</p> <p>a) IT, Unit Managers, Team Leaders</p> <p>a) Audits to begin by Nov. 20, 2015.</p>	

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	<p>hours.</p> <p>3. Medical record #N2 indicated the patient received IV pain medication while enroute to the hospital after a fall. The patient arrived in the Emergency Department (ED) at 1732 hours on 03/12/15 and remained there until going to surgery at 2313 hours. The record lacked documentation of a pain assessment while in the ED.</p> <p>4. Medical record #N3 indicated the patient received oral medication at 0920 hours on 03/25/15 for a pain score of 4 with lower abdominal cramping, but the record lacked documentation of any pain reassessment.</p> <p>5. Medical record #N6 indicated the patient complained of neck pain with a rating of 8 upon arrival to the ED at 0831 hours on 05/12/15. The patient remained in the ED until admission at 1321 hours, but the record lacked documentation of any pain relief intervention or reassessment.</p> <p>6. Medical record #N7 indicated the patient complained of hip pain after a fall with a rating of 8 upon arrival to the ED at 1230 hours on 05/12/15. The patient remained in the ED until admission at 1529 hours, but the record lacked</p>		<p>a) HEAT ticket submitted to IT November 18, 2015.</p> <p style="text-align: center;"><b>Deficiency:</b></p> <p style="text-align: center;"><b>Corrective Action to be Taken:</b></p> <p style="text-align: center;"><b>Prevention of Future Deficiencies:</b></p> <p style="text-align: center;"><b>Responsible Parties:</b></p> <p style="text-align: center;"><b>Target Completion Date:</b></p> <p><b>0912:</b></p> <p>b) b) Failed to administer a prn Dulcolax suppository or otherwise address a patient's lack of a BM.</p> <p style="text-align: center;">b) Add to Mosby's policy: "Intervention for bowel treatment will be considered if patient does not have BM within 3 days."</p> <p>b) Develop Tip Sheet to review at Practice Council and disseminate to units.</p>	

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	<p>documentation of any pain relief intervention or reassessment. The record also indicated the patient received oral medication for a pain score of 6 at 0947 hours on 05/13/15, but the record lacked documentation of a pain reassessment until 2200 hours.</p> <p>7. Medical record #N8 indicated the patient complained of abdominal pain with a rating of 4 at 1222 hours on 05/24/15 and received medication. The only medication documented was Zofran IV (nausea medication) at 1251 hours. Documentation indicated the patient was sleeping at 1500 hours, but there was no pain reassessment until 1900 hours.</p> <p>8. Medical record #N9 indicated the patient received oral medication at 2035 hours on 06/12/15 for a pain score of 8 for leg pain, but the record lacked documentation of any pain reassessment until 0513 hours on 06/13/15.</p> <p>9. Medical record #N12 indicated the patient received oral medication at 1133 hours on 08/13/15 for a pain score of 5 after knee surgery, but the record lacked documentation of any pain reassessment until 1524 hours.</p> <p>10. At 2:45 PM on 09/14/15, staff member #45, the Clinical Quality</p>		<p>b) Staff Development Specialist is responsible for both the revision to the Mosby's policy and for the development and dissemination of the related Tip Sheet.</p> <p>b) Policy revised in Mosby's by November 30, 2015.</p> <p>Tip Sheet to Nursing Practice Council at the December 8, 2015 meeting.</p> <p><b>0912:</b></p> <p>c) Failed to ensure fall risk assessment interventions were in place for 1 of 3 ICU patients.</p> <p>c) Modify fall policy to state that comatose, brain death or paralyzed patients are considered a low fall risk.</p> <p>c) Audit developed and performed for compliance with fall policy.</p>				

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	<p>Analyst, confirmed the findings for medical records #N1, N2, and N3.</p> <p>11. At 9:30 AM on 09/15/15, staff member #46, ED Quality, indicated he/she also checked and could not find the pain assessments/reassessments for the ED documentation on the medical records reviewed.</p> <p>12. At 11:25 AM on 09/17/15, staff members #40 and #47, Unit Manager Registered Nurses, confirmed the lack of pain assessments/reassessments per policy for the medical records reviewed.</p> <p>13. Nursing flowsheets indicated patient #4 complained of pain at 1954 hours on 9/12/15, at 1742 hours on 9/13/15, and at 2135 hours on 9/13/15. The medical record lacked documentation that a pain reassessment was completed.</p> <p>14. Staff member #01 (Registered Nurse) verified at 10:30 a.m. on 9/15/15 that the pain reassessments were not completed for patient #4.</p> <p>15. Review of patient #6 medical record at 11:30 a.m. on 9/15/15 indicated the following: (A) He/she was admitted on 9/9/15. The medical record indicated that his/her last bowel movement (BM) was on 9/9/15.</p>		<p>Fall Team, Department Managers, Team Leaders</p> <p>Policy update completed and to committee for approval by Nov. 20, 2015.</p> <p>Implementation of revised policy December 8, 2015.</p> <p>Fall Team will review monthly unit audits until 90% compliance achieved</p> <p><b>0912:</b></p> <p>d) Failed to comply with hospital policy for patient privacy.</p> <p>d) Education will be done on privacy curtain use in PACU.</p> <p>d) Education will be done by email and at unit meetings. Audits will be completed until we reach 95% compliance.</p> <p>Manager, Team Leader,</p>	

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	<p>(B) An order was written on 9/10/15 at 12:37 p.m. for a Dulcolax suppository pm.</p> <p>(C) The medical record lacked evidence that the Dulcolax suppository had been administered or the patients lack of BM was addressed.</p> <p>(D) He/she was documented as a high risk for falls from 9/9/15 through 9/15/15.</p> <p>16. Staff member #02 (RN) verified at 11:30 a.m. on 9/15/15 that the patients lack of BM was not addressed or fall interventions were in place for patient #6. He/she indicated that a patient at high risk for falls would have yellow flag outside room, yellow socks on and the bed alarm turned on and the three (3) interventions were not in place for patient #6.</p> <p>17. Observation of patient #6 at 11:25 a.m. on 9/15/15 indicated the yellow flag was not posted outside the door, he/she did not have yellow socks on and the bed alarm was not turned on.</p> <p>18. Facility policy titled "STANDARDS OF PERIANAESTHESIA NURSING PRACTICE" last reviewed/revised 1/15 states on page 2 of 3: "3. To ensure patient confidentiality maintain privacy via use of curtains/doors."</p>		December 20, 2015	

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S 0952 Bldg. 00	<p>19. Facility policy titled "STANDARDS: ENVIRONMENTAL SET-UP FOR PACU" last reviewed/revised 4/7/15 states on page 1: "1. Each bay is in direct visual observation from a central vantage point. 2. Each Bay will provide:.....i. Curtain for privacy."</p> <p>20. Observation in the PACU beginning at 12:30 a.m. on 9/15/15 indicated there were no curtains pulled between the four (4) patients that were in the unit. One (1) patient was awake and looking at activity in the next bay.</p> <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><b>Based on document and staff interview, the hospital failed to administer blood transfusions in</b></p>	S 0952	Deficiency:	12/01/2015			

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	<p><b>accordance with approved medical staff policies and procedures for three (patients #5, 6, and 11) of twenty six patients.</b></p> <p><b>Finding(s) include:</b></p> <p><b>1. The policy, "Blood Products: Administering", approved 11/01/11, read: "After 15 minutes, reassess vital signs.... Transfusions should be completed within 4 hours.... Febrile nonhemolytic transfusion reactions. This reaction is reflected by any increase in temperature greater than 1 degree Centigrade (C) (1.8 degrees Fahrenheit (F)).... Treatment usually consists of stopping the transfusion..."</b></p> <p><b>2. In review of three patients receiving six blood units, three of these received-units did not have complete documentation, per policy, on the Crosshatch Transfusion Report Chart Copy form including:</b></p>		<p><b>Corrective Action to be Taken:</b></p> <p><b>Prevention of Future Deficiencies:</b></p> <p><b>Responsible Parties:</b></p> <p><b>Target Completion Date:</b></p> <p><b>0952: Nursing Service: Blood Administration:</b></p> <p>Failure to administer blood transfusions in accordance with approved medical staff policies and procedures for 3 of 26 patients.</p> <p><b>Standardize OFI (Opportunity for Improvement) form including standardizing the disciplinary action to be taken for recurrent deficiencies in practice.</b></p> <p>Unit Manager/TL will review OFI with RN involved and follow progressive disciplinary action as identified on the form.</p> <p><b>Lab will send correctible and non-correctible forms to units at time of identification of occurrence instead of batching and</b></p>	

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	<p><b>Patient #5</b> --Unit 5b, was administered on 7/01/2015 at 10:45 a.m.: While this unit had been started 10:45 a.m. the 15 minute vitals had also been documented at 10:45 a.m.</p> <p><b>Patient #6</b> --Unit 6a, was administered on 7/08/2015 at 6:20 p.m.: The unit had been picked up at the blood bank at 4:06 p.m. and completed at 10:35 p.m. which was 4 hours and 15 minutes.</p> <p><b>Patient #11</b> --Unit 11a, was administered on 6/17/2015 at 08:40 a.m.: 1) While this unit had been started 08:40 a.m. the 15 minute vitals had also been documented at 08:50 a.m. 2) The patient's initial temperature was documented at 97.0 F and the 15 minute temperature was documented at 100.3 F which was a rise of 3.3 degrees F.</p>		<p><b>sending monthly.</b></p> <p>Non-correctible copy will include error circled as FYI.</p> <ul style="list-style-type: none"> <li>· Reports showing compliance rate for the month: compliance for each unit will be sent to unit management/directors.</li> <li>· Blood Administration policy has been updated to reflect more current products.</li> <li>· Integrate blood administration simulation into NNO and annual unit skills day (attach OFI form, curriculum &amp; Mosby's policy).</li> <li>· Director of Patient Care Services</li> <li>· Nurse Manager</li> <li>· Blood Bank Supervisor</li> <li>· Manager of EE&amp;D</li> <li>· OFI Form completed and distributed to managers for use by December 1, 2015.</li> <li>· Blood Administration Policy revision completed by November 30,</li> </ul>	

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S 1022  Bldg. 00	<p><b>No documentation was available to indicate the ordering Physician had been informed of this 3.3 degree F temperature change to determine whether or not to discontinue the infusion; instead, the infusion was completed at 10:50 a.m.</b></p> <p><b>3. On 9/16/15 at 1:11:45 a.m., Staff member #30 acknowledged that the three above-listed patient blood units had incorrect documentation, per policy.</b></p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)</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 are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on document review, observation, and interview, the facility failed to ensure all medications were stored according to</p>	S 1022	<p>2015</p> <p>· Correctable and non-correctable forms being sent to units – completed. Was already in place and will continue.</p> <p><b>Deficiency: Corrective Action to be Taken: Prevention of Future</b></p>	09/18/2015
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	<p>policy.</p> <p>Findings included:</p> <p>1. Review of the facility policy "Daily Inventory Management", revised September 2015, indicated, "III. Responsibility: It is the responsibility of all pharmacy staff to provide safe medications to patients, follow regulatory guidelines for proper drug waste removal, and assure the integrity of the perpetual inventory count. ... 1. Expiration dates will be monitored via an electronic inventory system utilizing periodic cycle counts. Medications not contained within the inventory system ... will be inspected by designated staff and document completion within an electronic tracking software. The lead operations pharmacist will monitor assigned tasks and assure inspections are being performed."</p> <p>2. During the tour of of the Neuro Medical Intensive Care Unit (ICU) at 1:35 PM on 09/15/15, accompanied by staff members A3, the Patient Safety Officer, A5, the Operations Manager, A7, Nursing Director, and A48, the Unit Manager, a package of oral medications for a patient (dated 04/05/15) and 4 packages of culture swabs (expiration date of 03/2014) were observed in a</p>		<p><b>Deficiencies: Responsible Parties for columns 2 and 3</b></p> <p><b>Target Date: Give specific dates. Target Completion Date:</b></p> <p>1022 Locked med box was removed from wall. Locked Medication box will no longer be available to staff for use for medication storage. Engineering and Maintenance and Manager of NMICU Box was removed 09/16/2015, the day after the cabinet and its contents were observed. Completed 09/18/2015.</p>				

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S 1118 Bldg. 00	<p>locked wall-mounted cabinet in the hallway by the medication Omnicell.</p> <p>3. At 1:35 PM on 09/15/15, staff member A48 indicated medications were placed in the cabinet for return to pharmacy after a patient was discharged. He/she confirmed that patient was no longer at the facility and did not know why the medications were still there. He/she indicated this process was discontinued a while ago and also confirmed medications should not be stored with other supplies.</p> <p>4. At 12:10 PM on 09/16/15, staff member A35, the Pharmacist, indicated it was the responsibility of the pharmacy staff to check any drug storage areas.</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>			
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	<p>Based upon observation, staff interview and document review, the kitchen had maintained a condition in one of fifteen kitchen work areas which may present a hazard for employees, the hospital failed to comply with hospital procedures on weekly eyewash station checks in 11 areas of the hospital, and failed to meet the chemical manufacture safety precaution on the chemicals located in the main housekeeping storage room, in the Same-Day Surgery Department by securing two of two compressed gas cylinders and by discarding outdated supplies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. On 9/14/15 at 12:45 p.m., the surveyor observed that the room service beverage area contained an unchained gas cylinder used for dispensing beverages. This cylinder presented a potential physical hazard in the event it fell over and harmed an employee in its path.</li> <li>2. On 9/14/15 at 1:00 p.m., staff member #5 acknowledged that the above-listed cylinder was unchained.</li> <li>3. Deaconess Hospital Inc 2015 Safety Management Plan indicated the</li> </ol>	S 1118	<p><b>Deficiency:</b></p> <p><b>Corrective Action to be Taken:</b></p> <p><b>Prevention of Future Deficiencies:</b></p> <p><b>Responsible Parties:</b></p> <p><b>Target Completion Date:</b></p> <p><b>1118: Physical Plant:</b> No condition shall be created or maintained which may result in a hazard to patients, public or employees.</p> <p>a) Room Service beverage area: unchained gas cylinder.</p> <p>a) Added "Gas cylinder is chained" to the Assistant Manager's Daily Operations Recording Form. See Exhibit D</p>	12/30/2015

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	<p>organization shall comply with OSHA, Local, State, and Federal regulations.</p> <p>4. Occupational Safety &amp; Health Administration (OSHA) indicated emergency eyewashes and showers often go unused. It's important to test these devices regularly to help ensure they will function properly in an emergency. To ensure that eyewash stations and showers are always ready when needed, it is important that the requirements for test procedures and maintenance set forth in Z358.1-2014 be followed. The requirements for testing and maintaining eye, eye/face washes and showers are weekly testing. The weekly testing helps clear the supply lines of sediment and bacteria build-up that is caused from stagnant water.</p> <p>5. At 9:30 AM on 9/15/2015, the Emergency Department was toured. The decontamination room was observed with a shower and there was no inspection tag posted on the shower.</p> <p>6. At 9:38 AM on 9/15/2015, staff member #A49 (Director of ED) indicated eyewash inspection tags are to be attached to the equipment and maintained; however, he/she did not know who was responsible for maintaining the tags on the eyewash</p>		<p>a) Added "100% of time gas cylinder is chained" to the weekly Statement of Fact Log—QA Program. See Exhibit E</p> <p>Dietetics Manager, Main Campus.</p> <p>Completed November 16, 2015.</p> <p>1118: Physical Plant:</p> <p>b) 10 Eyewash stations not having weekly checks in Engineering and Maintenance and 1 decontamination shower in Emergency Department without weekly inspections.</p>	

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	<p>stations located in the decontamination room.</p> <p>7. Eye Wash preventive maintenance logs were reviewed with staff member #A10 (Deaconess Hospital Site Manager). The 2015 eyewash station tags attached to 10 Engineering &amp; Maintenance department's eyewash stations noted they were had weekly checks for the first 4 months of 2015; however, the tags were not initialed of completed inspection of the eye wash stations since April 2015. The eyewash tags indicated the eyewash stations should be inspected weekly.</p> <p>8. At 2:45 PM on 9/15/2015, staff member #A2 (Risk Manager) indicated weekly eyewash inspection was a requirement by the facility and per OSHA safety requirements. Each eye wash station should have a tag attached to the eyewash station that specifies weekly inspections are to be logged.</p> <p>9. At 1:45 PM on 9/16/2015, staff member #A10 (Deaconess Hospital Site Manager) indicated the staff member whom documented the weekly eyewash inspections; had been transferred and the weekly inspections were not assigned to a new staff member. The staff member</p>		<p>b) Weekly PMs were created for the Engineering &amp; Maintenance Eyewash stations on 9/21/15.</p> <p>b) The PM is scheduled to issue on a weekly basis. All PMs are monitored regularly for completion.</p> <p>Manager, Engineering &amp; Maintenance.</p> <p>Engineering and Maintenance: Completed 09/21/2015.</p> <p><b>Deficiency:</b></p> <p><b>Corrective Action to be Taken:</b></p> <p><b>Prevention of Future Deficiencies:</b></p> <p><b>Responsible Parties:</b></p> <p><b>Target Completion Date:</b></p> <p>1118</p> <p>b) <b>Emergency Department Shower.</b></p> <p>Emergency Department staff will be responsible to conduct a</p>	

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	<p>indicated the 10 eyewash stations located throughout the Engineering and Maintenance Departments have not been inspected since April of 2015 and they should of been checked weekly.</p> <p>10. During the tour of the Same-Day Surgery Department at 9:45 AM on 09/15/15, accompanied by staff members A3, the Patient Safety Officer, A6, the Chief Nursing Officer, A7, the Nursing Director, and A49, the unit team leader, the following observations were made:</p> <p>A. Two of two portable oxygen tanks (one lying on the floor and one standing up) unsecured in the oxygen room.</p> <p>B. One of one blood sampling kit with an expiration date of 02/2013 in a drawer at the nurses' station.</p> <p>C. Three of three 22 gauge Portex needles with an expiration date of 04/2013 in a drawer at the nurses' station.</p> <p>D. One of one 25 gauge Portex needle with an expiration date of 05/2015 in a drawer at the nurses' station.</p> <p>11. At 9:45 PM on 09/15/15, staff member A49 indicated all staff checked expiration dates of supplies, but this was not documented. He/she also indicated the oxygen tanks were usually stored on the patient carts.</p> <p>12. At 9:50 AM, staff member A3</p>		<p>weekly check of the shower function in the ED decontamination showers at Main campus ED and Gateway ED.</p> <p>ED staff will be educated to perform a weekly check on the showers in the ED's decontamination showers</p> <p><i>See weekly shower log attachment.</i></p> <p>ED Clinical Operations Supervisor</p> <p>Begin weekly checks 11/30/2015.</p> <p><b>1118: Physical Plant:</b></p> <p>c) 2 unsecured portable O2 tanks in MC SDCC (Same Day Care Center).</p> <p>c) O2 tanks were stored in appropriate places.</p> <p>c) Staff educated at unit meeting about appropriate place and how to</p>	

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	confirmed the oxygen cylinders needed to be stored upright and secured.		<p>store O2 Tanks. <i>(See Minutes attached.)</i></p> <p>SDCC Manager and Team Leader</p> <p>Completed October 6, 2015.</p> <p><b>1118: Physical Plant:</b></p> <p>d) Expired blood sampling kit and needles on SDCC.</p> <p>d) We will have no expired items in the unit.</p> <p>d) Will start recording monthly assignment of looking for expired items.</p> <p><i>(See Minutes attached.)</i></p> <p>SDCC Manager and Team Leader</p> <p>December 30, 2015</p>		

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S 1164 Bldg. 00	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)  (d) The equipment requirements are as follows: (2) There shall be sufficient		<p><b>1118: Physical Plant</b></p> <p>e) Failed to meet chemical manufacturer safety precautions on the chemicals located in the main housekeeping storage room.</p> <p>e) Two Eyewash Stations have been ordered for the housekeeping storage rooms.</p> <p>e) Once installed, maintenance will perform an annual pm and Environmental Services staff will maintain a log of the weekly checks.</p> <p>Manager, Engineering &amp; Maintenance and Manager, Environmental Services</p> <p>December 18, 2015</p>	

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	<p>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 and staff interview, the facility failed to assure preventive maintenance was conducted on Deaconess Gateway Hospital parallel bars, wooden therapy steps, and a walker .</p> <p>Findings included:</p> <p>1. Medical Equipment Management Plan (last reviewed 10/2014) indicated fixed and portable patient care equipment used for diagnosis, treatment, monitoring, and direct care of individuals. The Clinical Engineering Associates manage the schedule and timely completion of the calibration, inspection, and maintenance activities required for for safe, reliable performance of medical equipment. All patient care equipment is screened at time of delivery and evaluated the frequency of preventive maintenance. All medical equipment shall have an asset tag placed on them when they are first inspected before intitial use in the hospital.</p>	S 1164	<p><b>Deficiency:</b></p> <p><b>Corrective Action to be Taken:</b></p> <p><b>Prevention of Future Deficiencies:</b></p> <p><b>Responsible Parties:</b></p> <p><b>Target Completion Date:</b></p> <p><b>1164: Physical Plant:</b> There were no PMs conducted on <i>parallel bars</i>, <i>wooden therapy steps</i>, and a <i>walker</i> at Gateway PHOI.</p> <p>PM was performed on both the parallel bars and the wooden steps on 11/11/2015. There are no PM services required for walkers. The walker will be inspected and a yellow sticker will be placed on it.</p> <p>The PM is scheduled to issue on an annual basis. All PMs are monitored regularly for completion. An initial inspection for the walkers will occur upon purchase and a yellow inspection sticker will be placed on the equipment.</p>	11/27/2015

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S 1186 Bldg. 00	<p>2. At 10:05 AM on 9/15/2015, the Rehabilitation Wound Care Department located at Deaconess Gateway Hospital had parallel bars, wooden therapy steps, and a walker that did not have an asset tag.</p> <p>3. At 11:00 AM on 9/16/2015, staff member #A10 (Deaconess Hospital Site Manager) indicated the Clinical Engineering Department did not assess the parallel bars, therapy wooden steps, and walker located at Deaconess Gateway Hospital.</p> <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</p>		<p>Manager, Engineering &amp; Maintenance</p> <p>11/27/2015</p>		

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	<p>management in accordance with federal and state rules.</p> <p>(E) A written fire control plan that contains provisions for the following:</p> <ul style="list-style-type: none"> <li>(i) Prompt reporting of fires.</li> <li>(ii) Extinguishing of fires.</li> <li>(ii) Protection of patients, personnel, and guests.</li> <li>(iv) Evacuation.</li> <li>(v) Cooperation with firefighting authorities.</li> </ul> <p>Based on documentation review and staff interview, the facility failed to ensure the documented fire drills for Deaconess Hospital were completed one per shift per quarter.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Fire Control Management Plan (last reviewed 10/2014) indicated fire drills are conducted in hospital one per shift per quarter: day's 8 am to 4 pm; evenings 4 pm to 11:30 pm; and nights 11:30 pm to 8am.</li> <li>2. Deaconess Hospital fire drills were reviewed for the first three quarter of 2015. The first three quarters of 2015 should have at least 9 documented fire drills: one per shift per quarter. Five of the nine fire drills held in 2015 did not evidenced the time the fire drill was completed; therefore, it could not be determined what shift the fire drill</li> </ol>	S 1186	<p><b>Deficiency:</b></p> <p><b>Corrective Action to be Taken:</b></p> <p><b>Prevention of Future Deficiencies:</b></p> <p><b>Responsible Parties:</b></p> <p><b>Target Completion Date:</b></p> <p><b>1186: Physical Plant:</b> safety management program (fire safety): 5 out of 9 of the fire drills at Main Campus for the first 3 quarters of 2015 did not have documentation of a time conducted and it could not be determined if there had been one drill per shift per quarter.</p> <p>On <b>09/28/2015</b>, the monthly Fire Drill PM was changed to mandate staff to list the date, time, and shift the drill occurred.</p> <p>The Fire Drill PM has been permanently changed for all future PMs.</p>	09/28/2015

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	<p>completed on.</p> <p>3. At 2:30 PM on 9/15/2015, staff member #A10 (Deaconess Hospital Site Manager) confirmed the fire drills held for Deaconess Hospital in 2015 were not complete because the time of the fire drill was omitted. The staff member indicated the fire drills are documented on the hospital's preventive maintenance program; however, the computer documentation omitted the time the fire drills are completed on some drills. This could be an data entry issue.</p>		<p>Manager, Engineering &amp; Maintenance</p> <p>Completed <b>09/28/2015</b>.</p>		