

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150150		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/20/2012	
NAME OF PROVIDER OR SUPPLIER DUPONT HOSPITAL LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2520 E DUPONT RD FORT WAYNE, IN 46825			
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S0000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 9/18/2012 through 9/20/2012</p> <p>Facility Number: 002408</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: cloughlin 09/27/12</p>	S0000	Corrective Action Plan Attached.				

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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S0554	<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 policy and procedure review, observation, and interview, the facility failed to follow manufacturer's directions for dating glucometer strips and control solutions to prevent outdated usage and failed to ensure outdated supplies were discarded and replaced.</p> <p>Findings included:</p> <p>1. The facility policy "Nova StatStrip Glucose Hospital Meter", effective 03/12, indicated, "...C. Materials- obtain from Materials Management: 1. StatStrip Glucose Test Strips 2. StatStrip Glucose Control Solutions- Strips and controls are: (1) Stored at Room Temperature (2) Do not refrigerate or freeze (3) Unopened containers are stable until the expiration date listed on the container. (a) Opened QC control containers are stable for three (3) months or until the expiration date listed on the container, whichever is first. (b) Opened test strips are stable six (6) months or until expiration date listed on the container, whichever is first.</p>	S0554	<p>1. Education has been provided in individual unit meetings regarding the process for dating the strips and control solutions for those departments in which expired solution and test strips were found. Education for the Emergency Department took place on 9/26/2012. Education for the BirthPlace occurred on 10/12/2012. The survey brought attention forth that many misconceptions were in place regarding the QC process and care of the test strips and solution. The nurse Educator will create housewide education for all nursing staff to standardize the process. The housewide education will be complete by 11/1/2012. The CNO will be responsible for overall implementation and over sight.</p> <p>2a. GEM III RNs have been assigned a cart and responsibility for stocking the cart. They have also been assigned the responsibility of checking the cart for expired items. Completed 9/26/2012. The ED Team Specialist is to spot check monthly to assure compliance on an ongoing</p>	11/01/2012			

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	<p>2. During the tour of the Emergency Department at 9:00 AM on 09/19/12, accompanied by staff members #A1 and A8, the following observations were made:</p> <p>A. An open container of plain packing strip material with an expiration date of 11/2011 in a cart in the triage area.</p> <p>B. Four of four Medtronic Input Introducer Sheaths, 2 expired 04/2012 and 2 expired 08/2012, in the equipment room.</p> <p>C. Five of seven BD spinal needles, 4 expired 09/2011 and 1 expired 02/2007, in the Med/IV cabinet.</p> <p>D. An open, but not dated, container of StatStrip Glucose Test Strips and open bottles of control solution, dated 3/6/12 on the "Discard Date" space, in one glucometer kit.</p> <p>E. An open, but not dated, container of StatStrip Glucose Test Strips in a second glucometer kit.</p> <p>3. During the tour of the Obstetrical Department at 9:40 AM on 09/19/12, accompanied by staff members #A1, A11, and A12, the following observations were made:</p> <p>A. Two open containers of StatStrip Glucose Control Solutions, one dated 01/18/13 and one dated 10/18/12 on the "Discard Date" space, in the post-partum</p>		<p>basis.2b. Materials Management has reviewed supplies and par levels and eliminated infrequently used items. Completed 9/26/2012. The ED Team Specialist is to spot check monthly to assure compliance on an ongoing basis.2c. Materials Management has reviewed supplies and par levels and eliminated infrequently used items. Completed 9/26/2012. The ED Team Specialist is to spot check monthly to assure compliance on an ongoing basis.2d. Stat Strips were disposed of immediately. Education has been provided in unit meetings regarding the process for dating the strips and control solutions. Completed 9/26/2012. The ED Team Specialist is to spot check monthly to assure compliance on an ongoing basis.2e. Stat Strips were disposed of immediately. Education has been provided in unit meetings regarding the process for dating the strips and control solutions. Completed 9/26/2012. The ED Team Specialist is to spot check monthly to assure compliance on an ongoing basis.3a. Statstrip Glucose Control solutions were disposed of immediately. Education has been provided in unit meetings regarding the process for dating the control solutions. Completed 10/12/2012. The Birthplace Team Leader is to spot check</p>				

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	<p>glucometer kit.</p> <p>B. One open, but not dated, container of StatStrip Glucose Test Strips and two open bottles of control solution, dated 09/02/12 on the "Discard Date" space, in the operating room glucometer kit.</p> <p>C. Two of five medication boxes in the C/S area contained Atropine with an expiration date of 09/17/12.</p> <p>4. During the tour of the Newborn Intensive Care Unit at 10:35 AM on 09/19/12, accompanied by staff members #A1 and A13, an open vial of Influenza Virus Vaccine with an open date of 10/17/11 and a manufacturer's expiration date of 30 June 12 was observed in the refrigerator. Staff member #A13 indicated that had been used for staff immunizations and should not have been in that refrigerator.</p> <p>5. During the tour of the Pre/Post Surgical area at 1:10 PM on 09/19/12, accompanied by staff members #A1, A32, and A33, the following observations were made:</p> <p>A. Five of five BBL Cultureswabs, one expired 04/2009 and four expired 05/2012, in the drawer of the medication area.</p> <p>B. One of one Select-A-Flow, expired 10/2010, two of two Arrow StimuCath nerve block kits, one expired 03/2011 and</p>		<p>monthly to assure compliance on an ongoing basis.3b. Stat Strips were disposed of immediately. Education has been provided in unit meetings regarding the process for dating the strips. Completed 10/12/2012. The Birthplace Team Leader is to spot check monthly to assure compliance on an ongoing basis.3c. The medication boxes were immediately removed and corrected upon finding. Completed 9/19/2012. The medication procedural trays have been placed on a daily monitoring schedule for compliance by pharmacy on an ongoing basis.4. The vial was removed immediately upon discovery. Completed 9/19/2012. The refrigerator contents will be reviewed for expired medications daily on an ongoing basis by pharmacy. This refrigerator was also added to the ongoing monthly check of medication refrigerators and AcuDose Machines.5a. Culture swabs have been pulled from the area as they are not used in this area. Completed 9/19/2012. The Pre/Post Team Specialist will spot check monthly for compliance on an ongoing basis.5b. A nurse was previously assigned to the block cart. A supply list has now been added to the cart noting the next item to expire. All supplies not utilized with the block procedures have been pulled from the cart. Completed</p>		

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	<p>one expired 05/2011, one of one BD Epidural tray expired 07/2011, and one of one bag of lipid solution expired 07/2010 in the block cart.</p> <p>6. At 1:30 PM on 09/19/12, staff member #A1 acknowledged the discrepancies with the dating of the glucometer supplies and the inconsistencies with the staff's understanding of dating and length of effectiveness of the supplies according to manufacturer's recommendations.</p>		<p>9/21/2012. The Pre/Post Team Specialist to spot check monthly for compliance on an ongoing basis.6. Education has been provided in individual unit meetings regarding the process for dating the strips and control solutions for those departments in which expired solution and test strips were found. Education for the Emergency Department took place on 9/26/2012. Education for the BirthPlace occurred on 10/12/2012. The survey brought attention forth that many misconceptions were in place regarding the QC process and care of the test strips and solution. The nurse Educator will create housewide education for all nursing staff to standardize the process. The housewide education will be complete by 11/1/2012.</p>		

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S0610	<p>410 IAC 15-1.5-2 INFECTION CONTROL 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, documentation review, and staff interview, the facility failed to ensure high-protein nutrient tube feeding supplements were stored properly in the Dry Storage Room of the Kitchen.</p>	S0610	1, 2, and 3. All supplements were pulled and discarded immediately. Completed 9/19/2012. Supplements have been stored in original shipping boxes to be kept away from intense light. Completed 9/19/2012. A covered cart has been ordered on 10/18/2012. Upon receipt of cart, supplements will be stored in the covered cart. Dietary Team Specialist will be	09/21/2012

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	<p>Findings included:</p> <ol style="list-style-type: none"> At 10:38 AM on 9/19/2012, the Kitchen's Dry Storage Room was toured. A gray plastic storage rack containing 4 shelves was observed storing assorted nutrient tube feeding supplements. The assorted items were removed from their cases and were placed on the shelves of the storage rack. Above the storage racks and other locations throughout the Dry Storage Room were 4-bulb ceiling mounted fluorescent light fixtures. The manufacturer's label of Jevity 1.2 Cal high-protein nutrition with fiber states, "Contains light-sensitive nutrients." At 10:55 AM on 9/19/2012, staff member #10 indicated there were 146 liters of assorted nutritional tube feeding supplements stored on the shelf under the room's fluorescent bright lights and the staff member confirmed the assorted liquid tube 		responsible for over sight of improvement. Dietary Team Specialist to spot check compliance with weekly kitchen inspection to assure compliance until compliance is 100% for 4 weeks.	

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	feeding supplements all contained light-sensitive nutrients.			
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S0762	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(13)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(13) A discharge summary authenticated by the physician. A final progress note may be substituted for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instruction given to the patient and family.</p> <p>Based on policy and procedure review, medical record review, and interview, the facility failed to ensure 2 of 2 newborn records (#N16 and N18) and 3 of 14 discharged inpatient records (#N8, N13, and N20) reviewed contained a discharge summary or final progress note and 2 of 2 newborn records contained pertinent discharge instructions.</p> <p>Findings included:</p> <p>1. The facility policy "Discharge Summary", last reviewed 12/09, indicated, "...A. A discharge summary shall be dictated on all medical records of hospitalized inpatients. ...B. A final hand written progress not may be substituted for the discharge summary in the case of</p>	S0762	<p>1. Policy reviewed. No changes made to policy. Completed 9/21/2012. Education has been provided to physicians regarding the necessary components to be documented in a discharge summary. A check list has been developed and posted in the Newborn Nursery to assist physician in the appropriate documentation. Completed 10/17/2012. An audit of 10 charts/month will be conducted to assure compliance of the policy by the Quality Department. Information will be presented to physicians at the clinical department meetings on an ongoing basis until compliance reaches 100% for four consecutive months. CMO will be responsible for the improvement project.3. Education has been provided to physicians regarding</p>	10/17/2012			

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	<p>guests with problems of minor nature who require a forty-eight hours of less period of hospitalization. This applies for normal newborn infants regardless of length of stay and normal vaginal deliveries. The final progress note should include: 1. Outcome of hospitalization 2. Disposition of the case 3. Instructions given and provisions for follow-up care 4. Discharge diagnosis."</p> <p>2. The medical record for newborn #N16, born 07/09/12 and discharged 07/11/12, indicated a discharge exam by the physician the day of discharge, but no final progress note containing the items specified by the policy. The Neonatal Admission Record contained some visitation notes of the condition of the infant, but were from 1730 on 07/10/12. The record lacked documentation of infant discharge instructions.</p> <p>3. The medical record for newborn #N18, born 07/10/12 and discharged 07/12/12, indicated an incomplete discharge exam, dated 07/11/12 at the top of the page, but without a date, time, or physician signature at the bottom of the page in the spaces designated for this information. The record also lacked a final progress note containing the items specified by the policy.</p>		<p>the necessary components of the newborn exam. A check list has been developed and posted in the Newborn Nursery to assist physician in the appropriate documentation. Completed 10/17/2012. An audit of 10 charts/month will be conducted to assure compliance of the policy by the Quality Department. Information will be presented to physicians at the clinical department meetings on an ongoing basis until compliance reaches 100% for four consecutive months. The CMO will be responsible for the improvement project. Infant Discharge instructions have been corrected in the computer system and no longer contain inappropriate information. Completed 10/12/2012.4, 5, 6. Education has been provided to physicians regarding the necessary components to be documented in a discharge summary. Completed 10/17/2012. An audit of 10 charts/month will be conducted to assure compliance of the policy by the Quality Department. Information will be presented to physicians at the clinical department meetings on an ongoing basis until compliance reaches 100% for four consecutive months. The CMO will be responsible for the improvement project.7. Education with screen shots presented to nursing staff at unit</p>				

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	<p>The discharge instruction sheet for the infant indicated, "Call Physician for: - A weight gain of 5 pounds or more in 1 week. - Fever greater than 101 degrees. -New onset or change in pain. -New onset or change in shortness of breath. -New onset or change in swollen feet or legs. -Any other questions or concerns." The form continued, "Smoking is harmful to your health and as a health care provider we encourage you to stop smoking." A list of smoking cessation information continued and this information was the same as the information on the infant's mother's discharge information.</p> <p>4. The medical record for patient #N8, admitted 05/21/12 and discharged 05/22/12, lacked a discharge summary or final progress note containing the required information.</p> <p>5. The medical record for patient #N13, admitted 07/26/12 and discharged 07/28/12, lacked a discharge summary or final progress note containing the required information.</p> <p>6. The medical record for patient #N20, admitted 08/25/12 and discharged 08/29/12, lacked a discharge summary.</p> <p>7. At 11:00 AM on 09/20/12, staff</p>		<p>meetings regarding proper documentation on how to include the discharge instructions in the permanent medical record. Completed 10/12/2012. A monthly audit will be conducted by the Nursery Team Specialist of 10 charts to assure compliance on an ongoing basis until compliance reaches 100% for four consecutive months. The CNO will be responsible for the improvement project.</p>		

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	members #A1 and A11, who navigated the electronic medical records on the computer, confirmed the findings. Staff member #A11 indicated discharge care of the infant was covered in a booklet, but that was not indicated on the discharge documentation in the records.			

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S0952	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on medical record review and interview, the facility failed to administer blood transfusions according to the physician's orders for 1 of 5 patient records reviewed who received blood (#N11).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The medical record for patient #N11 indicated a physician order from 02/27/12 to infuse two units of PRBC (Packed Red Blood Cells) and to infuse each unit over 2 hours. The medical record for patient #N11 indicated the first unit of blood was started at 1315 on 02/27/12 and was completed at 1438 on 02/27/12, one hour and 23 minutes later. The record lacked any documentation to indicate why the unit did not infuse over 2 hours as ordered. 	S0952	<p>1, 2, 3, 4. Nursing staff was re-educated on a 1-1 basis for clear understanding regarding the infusion of blood and blood products. Completed 9/21/2012. Education was presented in unit meetings regarding timeframes for blood infusion and the necessity to follow physician orders for the timeframes. Complete 10/11/2012. The Quality Team will add infusion timeframes to audits of all blood on an ongoing basis. Findings will be presented to teams weekly. The CNO is responsible for the improvement project.</p>	10/11/2012			

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	<p>3. The medical record for patient #N11 indicated the second unit of blood was started at 1450 on 02/27/12 and was completed at 1616 on 02/27/12, one hour and 26 minutes later. The record lacked any documentation to indicate why the unit did not infuse over 2 hours as ordered.</p> <p>4. At 11:00 AM on 09/20/12, staff member #A1, who navigated the electronic medical record on the computer, confirmed the findings.</p>				

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S1118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure all personal protective equipment (PPE) was utilized and proper rinsing of medical instruments when using Cidex OPA in the Imaging Department, failed to use PPE when handling batteries for the two floor scrubbers located in the Materials Handling Department, failed to ensure 3 Hydrogen tanks and 1 Helium tank were secured in the Medical Gas Storage Room and failed to assure availability of an eye-washing station when checking batteries for the generator in the Generator Room.</p>	S1118	<p>1. Impervious gowns have been purchased and place in the room for use with high level disinfection. Completed 9/20/2012. The Team has been educated regarding the appropriate high level disinfection procedure in unit meetings. Completed 9/24/2012. The 20-Ounce jars were removed. Completed 9/20/2012. Gallon containers have been purchased and place in the HLD area. Completed 9/20/2012. Department policy has been revised to reflect changes. Completed 10/12/2012. Education has been provided to all Team Members regarding proper HLD technique. Completed 9/20/2012. Visualization of the procedure will be conducted weekly to assure compliance with the policy changes until complete compliance is noted for four consecutive weeks. The COO is</p>	10/15/2012	

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	<p>Findings included:</p> <ol style="list-style-type: none"> At 1:30 PM on 9/19/2012, room #1276 in the Imaging Department was inspected. The room stores the high-level disinfectant Cidex OPA. The room had goggles and gloves; however, aprons were not observed in the room. The room contained a single handwashing sink. On the counter right of the sink were 3 20-ounce 'Mason' jars filled with water. A probe from the ultrasound machine was observed soaking in 1 of the 3 20-ounce 'Mason' jars. The Cidex OPA Instruction User Manual requires the following PPE to be worn when disinfecting devices: gloves of appropriate type and length, eye protection, and fluid-resistant gowns. Cidex OPA rinsing procedure for medical devices states, "Thoroughly rinse the semi-critical medical device by immersing it completely in 2 gallons of water for a minimum of 1 minute; remove the device and 		<p>responsible for the improvement project.2. The 20-Ounce jars were removed. Completed 9/20/2012. Gallon containers have been purchased and place in the HLD area. Completed 9/20/2012. Department policy has been revised to reflect changes. Completed 10/12/2012. Education has been provided to all Team Members regarding proper HLD technique. Completed 9/20/2012. Visualization of the procedure will be conducted weekly to assure compliance with the policy changes until complete compliance is noted for four consecutive weeks. The COO is responsible for the improvement project.3. Impervious gowns have been purchased and place in the room for use with high level disinfection. Completed 9/20/2012. The Team has been educated regarding the appropriate high level disinfection procedure in unit meetings. Completed 9/24/2012. The 20-Ounce jars were removed. Completed 9/20/2012. Gallon containers have been purchased and place in the HLD area. Completed 9/20/2012. Department policy has been revised to reflect changes. Completed 10/12/2012. Education has been provided to all Team Members regarding proper HLD technique. Completed 9/20/2012. The COO is responsible for the</p>		

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	<p>discard the rinse water; repeat this step two more times with fresh 2 gallons of water."</p> <p>3. At 1:40 PM on 9/19/2012, staff member #23 indicated he/she handles the use of the Cidex OPA high level disinfectant. The staff member indicated he/she has never worn a gown or apron when disinfecting semi-critical devices. The staff member indicated he/she rinses the devices in each of the three 20-ounce 'Mason' jars 1-minute each. The staff member confirmed he/she was not complying with PPE requirement and rinsing method when handling of Cidex OPA.</p> <p>4. At 2:20 PM on 9/19/2012, the Material Handling Department was toured. The department had two industrial floor scrubbers with batteries and 1 of the 2 scrubbers was observed being charged. During the tour of the department, PPE for checking the batteries of the floor scrubbers were not</p>		<p>improvement project.4, 5, 6. PPE has been installed next to floor scrubber for easy access when changing batteries. Completed 10/12/2012. Education has been provided to team members regarding appropriate handling of caustic materials and need for PPE. Completed 9/21/2012. The COO is responsible for the improvement project.7, 8. Tanks were permanently removed from facility. Completed 10/5/2012. Education has been provided to team regarding safe storage of gas tanks and need for chaining the tanks. Completed 10/15/2012. The COO is responsible for the improvement project.9, 10, 11. The Lead Acid-filled batteries have been replaced with maintenance free batteries. Completed. They will be placed on a scheduled 24-36 month replacement schedule on an ongoing basis. With the change to maintenance free batteries, no eye-wash station is required. The COO is responsible for the improvement project.</p>	

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	<p>observed in the department.</p> <p>5. The maintenance Guide of the Hydro-Retriever floor scrubbers requires the fluid levels of the batteries to be checked after being charged. The maintenance Guide Warning states, "Use extreme caution when working with batteries. Sulphuric acid in batteries can cause severe injury if allowed to contact the skin or eyes. Explosive hydrogen gas is vented from the batteries through openings in the batteries caps. This gas can be ignited by any electrical ac, spark, or flame. When servicing batteries, remove all jewelry, do not smoke, wear safety glasses, rubber gloves, and a rubber apron, work in well ventilated area and do not touch more than one battery terminal at a time."</p> <p>6. At 3:10 PM on 9/19/2012, staff member #25 indicated the Material Handling Department does not have any PPE available to use when checking the fluid levels of the</p>			

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	<p>floor scrubber's batteries. Staff member #25 confirmed he/she does not use PPE when checking the fluid levels of the batteries.</p> <p>7. At 3:25 PM on 9/19/2012, the Medical Gas Storage Room was toured. To the left of the entry of the room, 3 'H' Nitrogen cylinder tanks and 1 helium cylinder tank was observed unsecured.</p> <p>8. At 3:30 PM on 9/19/2012, staff member #6 confirmed the 4 'H' cylinder tanks should have been chained and secured to keep from falling over to cause safety hazard.</p> <p>9. At 3:45 PM on 9/19/2012, the Generator Room was toured. The yellow diesel generator was observed with 2-12 volt batteries. The batteries were not maintenance free batteries and there was no availability to an eye-washing station to provide a continuous flushing of eyes for 15 minutes if needed.</p>			

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	<p>10. Dupont Hospital Safety Management program, last reviewed 4/23/12, was designed to assure compliance with applicable codes and regulations. Because 1910.178 does not have a specific requirement for eyewash facilities, the general standard at 1910.151 applies. When necessary, facilities for drenching or flushing the eyes 'shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which states, at section 7.4.4, that eyewash facilities are to be located to require no more than 10 seconds to reach but that where a strong acid or caustic is used, the unit should be immediately adjacent to the hazard."</p> <p>11. At 3:50 PM on 9/19/2012, staff member #6 confirmed there should be an eye-wash station available in</p>			

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	case the acid from the batteries comes in contact with the technician when he/she conducts their weekly battery checks on the generator.			
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