

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/16/2014
NAME OF PROVIDER OR SUPPLIER  COLUMBUS REGIONAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 E 17TH ST COLUMBUS, IN 47201		
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S000000	<p>This visit was for a State hospital licensure survey.</p> <p>Dates: 1/14/2014 through 1/16/2014</p> <p>Facility Number: 005099</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>QA: claughlin 01/29/14</p>	S000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S000362	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on documentation review, the facility failed to notify Indiana Organ Procurement Organization (IOPO) for 4 hospital deaths in</p>	S000362	Tag S 03621. How are you going to correct the deficiency?1.a February 6, 2014 Four deaths reviewed by Manager of Emergency Department, Manager of Critical Care Unit, and IOPO	02/06/2014			

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	<p>2013.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Hospital Procurement Agreement with IOPO signed in August, 2007; Article H section 2a states, "Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died in the Hospital."</li> <li>Columbus Regional Hospital Donation 2013 Statistics and Benchmarks report identified the hospital had 182 deaths for 2013. However, the Donation 2013 Statistics and Benchmarks identified only 178 deaths were reported to IOPO. Therefore, 4 hospital deaths were not reported to Indiana Organ Procurement Organization for 2013.</li> <li>At 11:15 AM on 1/16/2013, staff member #5 confirmed Columbus Regional Hospital Donation 2013 Statistics and</li> </ol>		<p>representative. One case removed from list due to patient being Hospice Inpatient (our hospital provides overflow beds per contract when Inpatient Hospice at capacity). Second case removed due to confirmation (documentation of certification/referral number) that case called timely. Revised IOPO report corrected and resent denoting only 2 cases not reported.1.b. February 6, 2014 Meeting held with Emergency Department Charge Nurses and Manager of Emergency Department to review policy and expectation that all deaths to be called to IOPO that enter emergency department despite status arrival.2. How are you going to prevent the deficiency from recurring in the future?2.a. Monitor monthly IOPO dashboard for deaths not reported for chart review. Emergency Department Manager added to email list for monthly dashboard distribution on February 3, 2014.2.b. Emergency Department Manager to attend quarterly IOPO meetings. Next meeting scheduled for April 24th. Emergency Department Manager has accepted meeting invitations.2.c. Emergency Department Manager provided IOPO education reinforcing need to call deaths to IOPO to Emergency Patient Care Coordinators (PCCs) on February 6, 2014. (PCCs are responsible to</p>				

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	Benchmarks report identified the hospital had 182 deaths for 2013 and only 178 were reported to IOPO. The staff member confirmed two of the four deaths were hospital misses; however, the other two deaths were dead on arrival. Those two deaths on arrival were given hospital patient identification numbers and were made part of the IOPO hospital statistic reporting system.		make calls to IOPO.)2.d. Emergency Department Manager to provide IOPO education to the Emergency Department Physician Section meeting on February 25, 2014, reinforcing need to call deaths to IOPO and the impact of physician compliance that supports timely and accurate calling.2.e. Emergency Department staff education to be held on March 18 and 19th 2014 on IOPO requirements, emphasis on timely and accurate notification to IOPO.3. Who is going to be responsible for numbers 1 and 2 above?1.a CCU Nurse Manager1.b. ED Nurse Manager2.a CCU Nurse Manager and ED Nurse Manager2.b. ED Nurse Manager2.c. ED Nurse Manager2.d. ED Nurse Manager2.e. ED Nurse Manager4. By what date are you going to have the deficiency corrected? February 6, 2014There have been no further incidents (all deaths reported timely to IOPO since 10/15/2013.)		

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S000406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and staff interview, the facility failed to ensure Behavioral Health Laundry services were part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <p>1. Columbus Regional Hospital 2013 Quality Improvement Plan implements all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p>	S000406	S 04061. How are you going to correct the deficiency?1.a. Behavioral Health staff will log compliance with chemicals used and concentration levels for each wash cycle.1.b. Monthly compliance rate will be sent to Clinical Quality Management to be entered on the Quality and Safety QA report.2. How are you going to prevent the deficiency from recurring in the future?2.a. Compliance rate will be reviewed quarterly at the Quality and Safety Practice Council.2.b. At least annually the compliance rate will be reviewed by the Board of Trustees.3. Who is going to be responsible for numbers 1 and 2 above?Manager of Behavioral Health for 1.a. and 1.b.and Director of Clinical Quality Management for 2.a and 2.b.4. By what date are you going to have the deficiency corrected?	02/10/2014			

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S000554	<p>2. Columbus Regional Hospital Mental Health Personal Laundry Policy (Last updated 7/2011) states, "Each patient will be provided the opportunity to launder their own clothing with supervision of the nursing staff as assessed by the treatment team."</p> <p>3. At 10:00 AM on 1/16/2014, staff member #5 indicated Behavioral Health Laundry services were part of its comprehensive quality assessment and improvement (QA&amp;I) program. The staff member could not provide any documentation the laundry services were being evaluated.</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>		February 10, 2014				

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	<p>Based on observation and interview, the facility failed to ensure a safe environment for patients by checking supplies to prevent outdated usage and failed to ensure clean supplies and equipment were protected from contamination in the Emergency Department (ED).</p> <p>Findings included:</p> <p>1. During the tour of the Pediatric Unit at 3:45 PM on 01/14/14, accompanied by staff members A5, A6, A8, and A22, the following items were observed in the Pediatric Broselow cart:</p> <p>A. One of one CO2 indicator with an expiration date of 12/2013 and one of one Pleural Drainage set with an expiration date of 06/2013 in the red/pink drawer.</p> <p>B. One of one CO2 indicator with an expiration date of 12/2013 in the purple drawer.</p> <p>C. One of one CO2 indicator with an expiration date of 12/2013 in the yellow drawer.</p> <p>D. One of one CO2 indicator with an expiration date of 12/2013 in the white drawer.</p> <p>2. During the tour of the ED at 9:15 AM on 01/15/14, accompanied by staff members A5, A6, A12, and A23, the</p>	S000554	<p>S 0554 1. How are you going to correct the deficiency?1.a The outdated supplies were removed from the Broslow cart on the Pediatric unit and replaced on 1/14/14.1.b. Emergency Department Treatment cart was removed totally, not to return, on 1/15/14.1.c. Trash bags, linen bags, blood culture bottles and urine cups moved to ambulance bay shelving on 1/15/14. Clean bedside commodes removed from soiled room on 1/15/14. Work order placed to add shelving in a closet on 1/15/14 and then the toner and ink cartridges were moved to shelving in the closet on 1/23/14.2. How are you going to prevent the deficiency from recurring in the future?2.a. A clipboard with each item on the Broslow cart listed with the expiration date is located on top of Broslow Cart on the Pediatric unit. The Special Order staff member will check the clipboard, update items and dates on clipboard the first week of each month. The clipboard will be initialed when checked and any lack of completion of these tasks will be counseled as job performance deficits.2.b. All par leveled items moved out of soiled room. 2.c. Distribution Services staff notified of new location of par leveled items.2.d. Emergency Department Leadership will round in soiled area daily to assure no clean items in area. Leadership</p>	02/08/2014			

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	<p>following items were observed in the hallway treatment cart:</p> <p>A. Eight of eight packages of gauze squares with an expiration date of 08/2013.</p> <p>B. Eight of twelve packages of Biogel sterile gloves, two expired 09/2013, two expired 10/2013, and four expired 12/2013.</p> <p>C. One of one pneumothorax kit with an expiration date of 07/2013.</p> <p>D. One of one pneumostat chest drain valve with an expiration date of 10/2013.</p> <p>E. One of one BD Vacutainer urine cup kit with lab tubes that expired 10/2012.</p> <p>The soiled room was observed containing filled biohazard containers, trash cans, and other soiled items along with two racks of clean supplies (clean trash and linen bags, clean culture and urine cups). Three clean and patient-ready bedside commodes were also observed in the room with the soiled items.</p> <p>3. At 9:30 AM on 01/15/14, staff member A23 indicated the paramedics checked the carts monthly for outdated supplies, but also indicated there was no documentation of this.</p>		<p>will counsel staff as needed.2.e. Emergency Department staff educated via HUDDLE NOTE on 1/17/14, not to place clean items in soiled room.3. Who is going to be responsible for numbers 1 and 2?Pediatric Nurse Manager for 1.a and 2.a. Emergency Department Nurse Manager for 1.b., 1.c, 2.b, 2.c, 2.d and 2.e.4. By what date are you going to have the deficiency corrected? February 8, 2014</p>				

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S000610	<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 and documentation review, the facility failed to ensure high-protein Enternal tube-feeding supplements were stored properly in the Dietary Department.</p> <p>Findings included:</p>	S000610	S 06101. How are you going to correct the deficiency?1.a. All exposed tube feeding products were discarded on 1/14/142. How are you going to prevent the deficiency from recurring in the future?2.a. Tube feeding products containing light-sensitive nutrients will be stored covered in containers. When the container is opened, the open end of the container will remain attached to	01/16/2014			

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	<p>1. At 1:00 PM on 1/14/2014, the Kitchen of the Dietary Department was observed storing Abbott Enteral Feeding supplements on wired shelves under florescent ceiling lights. The staff were observed with carton's sides cut open exposing the two bottles of the carton to the fluorescent lighting. Loose assorted nutritional tube-feeding supplements were also observed stored on the cases. The department contained the following items that were observed stored in direct florescent lighting: 2 bottles of Osmolite 1.5 cal; 6 bottles of Vital AF 1.2 cal; 3 bottles of Nepro with carbsteady; and 3 bottles of Jevity 1.2 cal.</p> <p>2. The manufacturer Abbott product label of the assorted Enternal ready-to-eat nutritional supplements states, "Contain light sensitive nutrients." The manufacture indicates artificial</p>		<p>cover the opening and prevent exposure to light. 2.b.Compliance with the new practice will be monitored weekly for the first 3 months and then monthly.2.c. Food Service staff will be counseled for any violation found with disciplinary action to follow if no improvement with job responsibilities.3. Who is going to be responsible for numbers 1 and 2 above?Food Service Manager4. By what date are you going to have the deficiency corrected? January 14, 2014 deficiency was corrected.</p>	
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S000612	<p>light degrades vitamins such as riboflavin (B2), B6, and vitamin A. Vitamins losses occur gradually at low light exposure and faster in bright light. The manufacturer states, "Store product in the shipper or store on covered shelves or in closed cabinet prior to use."</p> <p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(xi) A program of linen management for personnel involved in linen handling. Based on documentation review and staff interview, the facility failed to ensure the Behavioral</p>	S000612	S 06121. How are you going to correct the deficiency?1.a. A peroxide base additive will be introduced into the wash solution that will be quality checked to a	02/10/2014			

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	<p>Health Laundry services were providing laundry services that meet the CDC guidelines for laundry services.</p> <p>Findings included:</p> <p>1. CDC guidelines for laundry services in health care facilities states, "Soaps or detergents loosen soil and also have some microbial properties. Hot water provides an effective means of destroying microorganisms, and a temperature of at least 71 C (160 F) for a minimum of 25 minutes is commonly recommended for hot-water washing. A satisfactory reduction of microbial contamination can be achieved at lower water temperatures of 22-50 C (71.6 to 122 F) when the cycling of the washer, the wash formula, and the amount of chlorine bleach are carefully monitored and controlled at a residual of 50-150 ppm during the chlorine bleach cycle."</p>		<p>level between 50 - 150 ppm when water temperature is &lt; 120 degrees Fahrenheit.2. How are you going to prevent the deficiency from recurring in the future?2.a. A wash cycle log will be filled out to monitor compliance to chemicals used and concentration levels.3. Who is going to be responsible for numbers 1 and 2 above?Director Outpatient Services and Therapies and Director of Facilities and Materials Management4. By what date are you going to have the deficiency corrected?February 10, 2014</p>		

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	<p>2, Columbus Regional Hospital Mental Health Personal Laundry policy (Last updated 7/2011) states, "To provide for laundering of personal garments with attention to appropriate infection control and safety measures. Mental Health staff will encourage patients self-reliance and self-care. Patients will be encouraged by staff to launder their own clothing under the supervision of mental health staff. The appropriate amount of detergent is to be used in accordance with package directions. Warm or hot water is to be used for visibly soiled items. One cup of bleach is to be cycled between each patient's load of laundry. Mixing of patient clothing should be prevented and special consideration should be given to patients with incontinence, wound infections, or lesions suspected or confirmed cases of scabies or pedicululosis."</p> <p>3. At 10:30 AM on 1/16/2014, staff member #5 indicated the</p>						

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S000754	<p>hospital cannot confirm the patient clothing that are washed in Behavioral Health are meeting the CDC requirements of proper disinfecting for patient clothing in a health care setting.</p> <p>4. At 11:30 AM on 1/16/2013, staff member #3 indicated water of 120 degrees Fahrenheit was pumped into the Behavioral Health washers. The staff member indicated the detergent that is utilized in the washer does not mention it can be used in a health care facility.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(f)(5)</p> <p>(f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following:</p> <p>(5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on policy review, medical record review, and interview, the facility failed</p>	S000754	S 07541. How are you going to correct the deficiency?1.a.	02/07/2014			

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	<p>to ensure all patient records contained an appropriately executed Consent for Treatment for 2 of 2 newborn records reviewed (#N4 and N7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Consent to Healthcare", last reviewed 01/19/11, indicated, "Policy: Individuals admitted to the hospital are requested to sign consent to healthcare. ...Definitions: Health Care means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition and includes admission to a health care facility." The policy continued with who could sign the consent and the process for a consent to be given for a minor.</li> <li>The medical records for patient #N4, born 08/02/13 and discharged 08/04/13, and patient #N7, born 11/02/13 and discharged 11/04/13, lacked documentation of a signed consent for generalized treatment.</li> <li>At 12:10 PM on 01/16/14, staff member A51 from the Obstetrics Unit, indicated the facility only had generalized healthcare consents signed for newborns if they had to remain in the</li> </ol>		<p>Consent for treatment for the newborn will be signed when the mother attends her Prepare Visit prior to delivery or upon admission to the Birthing Center for delivery if she does not present for Prepare visit. In the event that the Prepare visit occurs greater than 30 days before admission for delivery, the consent will be re-signed by the mother upon her admission for delivery. Birthing Center staff will have consents signed when patient presents for Prepare visit. Registration staff will have consents signed when patients are admitted without Prepare visit or if signed greater than 30 days prior.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <p>2.a. Educate secretarial staff on Birthing Center and Registration staff for need to obtain consent for newborn.</p> <p>2.b Starting February 7, 2014 Birthing Center staff will check for signed consent for mother and newborn and if not signed or if consent outdated will obtain consent.</p> <p>2.c. Add monitoring metric "Consent obtained for general treatment" to monthly chart audit for newborns.</p> <p>2.d. Provide feedback and coaching to staff for any omission regarding newborn consent.</p> <p>3. Who is going to be responsible for numbers 1 and 2? Manager of Birthing Center will provide education to Birthing Center staff and will be</p>				

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	hospital after the moms were discharged. He/she indicated there was no policy describing this system. He/she confirmed the newborns had their own patient numbers and received care and treatment, such as lab work, hearing screens, and newborn screens, as described in the policy.		responsible for chart audits and feedback/coaching regarding consents for newborns. Manager of Registration will provide education to Registrations staff regarding obtaining newborn consent to treat and resigning if greater than 30 days.4. By what date are you going to have the deficiency corrected?February 7, 2014		

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S000912	<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 descriptions with reporting responsibilities for all nursing staff positions. (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. (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 medical record review, policy and procedure review, and interview, the nurse executive failed to ensure assessments were done according to policy and protocol for 1 of 2 newborn</p>	S000912	S 09121. How are you going to correct the deficiency?1.a. Policy BC-C-1 00001r6-2 "Circumcision" reviewed to assure monitoring specifics in policy related to required circumcision	01/31/2014			

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	<p>patients (#N4).</p> <p>Findings included:</p> <p>1. The medical record for newborn #N4 indicated circumcision checks at 1030, 1100, 1130, and 1400 on 08/03/13. The record lacked any further checks prior to discharge at 1130 on 08/04/13.</p> <p>2. The facility policy "Circumcision", last reviewed 03/2012, indicated, "II. Registered Nursing staff will: ...E. Provide post circumcision care. ...Procedure: ...XVI. Check penis for bleeding immediately after, then at 15 minutes, one hour, and every eight hours."</p> <p>3. At 2:00 PM on 01/16/14, staff members A38 and A60, who were reviewing the electronic medical records, confirmed the lack of documentation of checks according to policy.</p>		<p>monitoring.1.b. February 3, 2014 educated Birthing Center staff and February 6, 2014 educate Pediatric staff of monitoring requirements for circumcision during staff meeting. February 3, 2014 placed educational poster in staff locker room.2. How are you going to prevent the deficiency from recurring in the future?2.a. Focused chart audits will occur for every infant circumcised from January 31, 2014 through February 28, 2014.2.b. Add to monthly chart audits "Circumcision monitoring followed per protocol". 2.c Any staff non compliant with monitoring protocol will be counseled regarding proper protocol. Disciplinary action to follow if no improvement in job responsibilities regarding circumcision monitoring.3. Who is going to be responsible for numbers 1 and 2?Birthing Center Manager and designee in Manager's absence.4. By what date are you going to have the deficiency corrected.January 31, 2014</p>		

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S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure Environmental Services Department conducted preventive maintenance on the plumbed eye-washing station as required by policies and procedures.</p> <p>Findings included:</p> <p>1. At 1:00 PM on 1/15/2014, the basement main Environmental Service Room was inspected. The room contained a plumbed eye-washing station on the wall. The eye-washing station had a Bradley tag on it to be signed by the staff who conducts the</p>	S001118	<p>S 11181. How are you going to correct the deficiency?1.a. On January 21, 2014 Environmental Services leadership has been assigned the weekly task of checking the operations of the eye wash station and signing the inspection check sheet to the Environmental Services Coordinator.2. How are you going to prevent the deficiency from recurring in the future?2.a. Environmental Services manager will monitor compliance and maintain records of weekly checks in Environmental Services office.3. Who is going to be responsible for numbers 1 and 2 above?Manager of Environmental Services4. By what date are you going to have the deficiency corrected?January 21, 2014</p>	01/21/2014			

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	<p>preventive maintenance of the eye-washing station. The last date the eye-washing station was inspected was noted 8/6/2012.</p> <p>2. The Bradley inspection tag states, "Test this unit each week. Test-operate valve(s) each week and sign below. Report any malfunctions immediately." Therefore, the Environmental Service Room's Eye-washing station was not inspected weekly as required.</p> <p>3. At 11:05 AM on 1/16/2014, staff member #3 indicated the hospital adheres to the preventive maintenance requirements that are in the 2009 ANSI Eye-washing procedures. The staff member confirmed the hospital was not meeting the ANSI Eyewash station guidelines.</p> <p>4. ANSI Eyewash 2009 guidelines states, "Proper maintenance and weekly testing is necessary to ensure the</p>						

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S001162	<p>Emergency Drench Showers and Eyewash Stations are functioning safely and properly. Weekly testing helps clear the supply lines sediment and bacteria build-up that is caused from stagnant water."</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:  (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.</p> <p>Based on observation, document review and staff interview, the facility failed to comply with manufacturer's recommendations for the M-2 Hydrocollator hot water holding temperature for the</p>	S001162	S 11621. How are you going to correct the deficiency?1.a. The preventative maintenance task for checking the hydrocollator has been modified to have the range for calibration tested at the operating parameters between 160 and 166 degrees Fahrenheit.2. How are you going	02/10/2014
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	<p>Physical Therapy Department.</p> <p>Findings included:</p> <p>1. The Operation Manual instructions for the use and operation of the Physical Therapy Chattanooga Hydrocollator M-2 Master Heating Unit note the thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to 166 degrees Fahrenheit. The temperature of the water should be checked before using the Steam Packs.</p> <p>2. The Clinical Engineering preventive maintenance work order specified the water temperature of the the M-2 Hydrocollator to be between 160 and 180 degrees Fahrenheit. Clinical Engineering work order CE-131537 noted the temperature passed at 172 degrees Fahrenheit.</p>		<p>to prevent the deficiency from recurring in the future?2.a. The preventative maintenance task will not be altered.3. Who is going to be responsible for numbers 1 and 2 above?Director of Facilities and Materials Management, Manager Facilities and Clinical Engineering4. By what date are you going to have the deficiency corrected?February 10, 2014</p>				

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S001166	<p>3. At 2:25 PM on 1/15/2013, staff member #3 indicated the Clinical Engineering Department was not adhering to the recommended hot water temperature of the Chattanooga M-2 Hydrocollator of 160 to 166 degrees Fahrenheit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks.</p> <p>Based on documentation review and staff interview, the facility failed to ensure Boiler Certificate of Inspection was posted in the Boiler Room.</p> <p>Findings included:</p>	S001166	<p>S 11661. How are you going to correct the deficiency?1.a. Notices that boiler permits are held in the Facilities Engineering office will be posted in the boiler room.2. How are you going to prevent the deficiency from recurring in the future?2.a. The notice will be permanently affixed within the boiler room.3. Who is going to be responsible for</p>	02/10/2014
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	<p>1. The Indiana Department of Homeland Security Boiler Certificate of Inspection section 1 states, "This Certificate of Inspection must be posted under glass in the room the vessel is located."</p> <p>2. At 2:15 PM on 1/14/2014, the Boiler Room was inspected. The Certificate of Inspection documentation was not observed posted in the room.</p> <p>3. At 2:30 PM on 1/14/2013, staff member #3 confirmed the boiler certificates or a copy of the certificates were not posted in the boiler room, but were kept in a file located in another area of the hospital. The staff member indicated the boiler certificates are mandated to be posted in the same room where the boilers are located as required by the Division of Fire and Building Safety.</p>		<p>numbers 1 and 2 above?Director Facilities and Materials Management, Manager Facilities and Clinical Engineering4. By what date are you going to have the deficiency corrected? February 10, 2014</p>				

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S001172	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation, the facility failed to ensure the sleep center storage room was maintained clean and orderly to protect the clean items stored in the storage room.</p> <p>Findings included:</p> <p>At 10:30 AM on 1/15/2014, the offsite sleep center was inspected. The storage room was shared with a hospice facility. The exterior wall was observed not drywalled and loose plastic was</p>	S001172	S 11721. How are you going to correct the deficiency?1.a. Items within the storage room that are distributed to patients or used within the plan of care are being removed from the space.2. How are you going to prevent the deficiency from recurring in the future?2.a. Routine rounding will occur to insure proper storage to eliminate the chances that dirt and debris does not come in contact with patient related supplies.3. Who is going to be responsible for numbers 1 and 2 above?Director of Outpatient Services and Director of Facilities and Materials Management4. By what date are you going to have the deficiency corrected? February 10, 2014	02/10/2014			

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	covering the yellow fiberglass insulation. Clean items were exposed to loose fiberglass fibers.			