

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150006	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2014
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH LA PORTE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005006</p> <p>Survey Date: 03/10/14 through 03/13/2014</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith Medical Surveyor</p> <p>QA: claughlin 03/26/14</p>	S000000		
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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 document review and employee interview, the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths.</p>	S000362	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. On 3/20/2014 IOPO representative, Cindy Alexander, was contacted	04/09/2014			

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the contract between the hospital and the Indiana Organ Procurement Organization (IOPO) indicated the 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>2. Review of the documentation presented failed to show all deaths were reported. Donation 2013 Statistics and Benchmarks indicated 17 deaths occurred in June 2013 and only 16 deaths were reported.</li> <li>3. Interview with Employee #A1 and review of the IOPO contract documentation on March 12, 2014 at 1:45pm, verified the information.</li> </ol>		<p>by the IU Health La Porte Donate Life Committee Chairperson in reference to a missed referral. In review of the 2013 IOPO Statistics and Benchmark report, IOPO was made aware that the missed referral in question was actually a patient discharged from the emergency room. On 4/8/2014 IOPO representative, Cindy Alexander, removed this missed referral explaining that it was an error in IOPO reporting. Documentation was provided to the IU Health La Porte Donate Life Committee Chairperson with corrections showing that IU Health La Porte Hospital had 100% compliance rate regarding all organ candidate referrals in the year 2013.2. How are you going to prevent the deficiency from recurring in the future? A printed report from IOPO will be reviewed in each monthly Donate Life Committee meeting. Previously the report consisted of one page, now the report will be three pages and will include information that was missed and will identify discrepancies regarding correct referral data. This report will be e-mailed to the IU Health La Porte Donate Life Committee Chairperson monthly by the IOPO representative. The IOPO representatives will also text the IU Health La Porte Donate Life Committee Chairperson to notify that an e-mail has been sent. The IOPO representative will discuss with</p>		

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			the chairperson any discrepancies noted at that time the report is generated. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? IU Health La Porte Donate Life Committee Chairperson.	

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S000554	<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 lack of policy and staff interview, the hospital failed to ensure a safe and healthful environment to minimize the risk of infection control exposure to patients and health care workers in one instance.</p> <p>Findings include:</p> <p>On interview on 3-13-14 between 11:00 AM and 12:00 PM, Staff Member #L9 indicated the business manager laundered hot pack covers in their home. Staff Member #L9 further indicated the facility did not have a policy for the laundering of hot pack covers.</p>	S000554	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>A policy and procedure, QNS-MNC-001 Maintenance Guidelines for Hydrocollator, for the process was developed and approved on 04/09/2014 by the Director of Wellness and Rehabilitation. All colleagues responsible for this process signed a copy of the new policy depicting their education and understanding of the new policy and process by 04/11/2014. All outpatient rehab centers will send their covers to the Crossing weekly starting on 04/11/2014. Once hot pack covers are collected at the Crossing, they will be sent over to the hospital and washed in the hospital laundry department. Laundry will return them to the Crossing and they will be distributed back to the rehab units.</p> <p>2. How are you going to prevent the deficiency from recurring in the future?</p> <p>All rehab colleagues were educated on the above process</p>	04/11/2014	

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			<p>and their responsibilities by the Director of Wellness and Rehabilitation during onsite rounding and department meetings by 04/11/2014. All colleagues responsible for the new process signed a copy of the new policy depicting their understanding of the new process by 04/11/2014. All hot pack covers will be marked identifying their location. Records of the hot packs cleaning process will be kept at the Crossing.</p> <p>3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The Assistant Director of Wellness and Rehabilitation</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, policy and procedure review, document review and staff interview, the hospital failed to ensure 4 fire extinguishers were securely stored in the purchasing storage area, failed to ensure an eyewash station in a chemical storage room and failed to ensure proper storage of pharmaceutical waste and IV (intravenous) fluids in 1 of 4 (ICU/CCU [Intensive Care Unit/Critical Care Unit]) areas toured.</p> <p>Findings include:</p> <p>1. Observation during facility tour on 3-10-14 between 2:54 PM and 4:00 PM, while accompanied by Staff Member #L5, four ABC type fire extinguishers were observed charged with a tag attached which read: "obsolete", and stored on the floor, unchained and unsecured, in the purchasing storage area.</p>	S001118	<p>1.1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. On 3/14/2014 four obsolete extinguishers were removed from a purchasing storage area by the Environment of Care Safety Coordinator and disposed of appropriately. 2. How are you going to prevent the deficiency from recurring in the future? In the future any identified obsolete/expired extinguishers found on scheduled environmental rounds will be removed from the facility immediately upon discovery and disposed of appropriately by the Environment of Care Safety Coordinator. All spare or additional extinguishers will be secured by a strap or chain on a storage shelf in the purchasing area to hold and secure them in the upright position until they are needed or removed for</p>	05/01/2014			

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	<p>2. Observation during tour of the LaPorte Regional Health Lifeworks Rehab off-site facility on 3-13-14 between 11:00 AM and 12:00 PM, while accompanied by Staff Member #L9, a container labeled "Pool Shock" alkalinity increaser made by "Haviland" was observed stored in a locker in the pool storage area adjacent to the pool room. The pool room and pool storage area did not have an eyewash station for emergency use.</p> <p>3. On 3-13-14 between 11:00 AM and 12:00 PM, review of policies indicated a policy titled: "Eyewash and Emergency Shower Testing," policy number "M-700.1," last revised on "9/05/2012" which read: "OSHA Standard 29 CFR 191.151(c) requires eyewash and shower equipment for emergency use where the eyes of body of an employee may be exposed to injurious materials..." and "...Ten-second travel time...equipment shall be in accessible locations that require no more than 10 seconds to reach..." and "Clear and level path of travel...Equipment shall be located on the same level as the hazard and the path of travel shall be free of obstructions that may inhibit the immediate use of the equipment..."</p> <p>4. On 3-13-14 between 11:00 AM and</p>		<p>replacement.3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The responsible person will be the Environment of Care Safety Coordinator.2.1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A new permanent eyewash station was installed in the pool storage area on 04/14/2014 by the engineering department. All Lifeworks colleagues that work in the pool area were notified and educated on the new eyewash station by the Assistant Director of Wellness and Rehabilitation on 04/14/2014. A copy of the existing policy, EC.02.05.01.4.g Maintenance of Safety Showers and Eyewash Stations, was posted by the Assistant Director of Wellness and Rehabilitation on 04/14/2014 for colleagues working in the pool area to read and sign that they understand the expectation for the use of the eyewash station. 2. How are you going to prevent the deficiency from recurring in the future? A permanent eyewash station was installed on 04/14/2014 and will be checked weekly by the assistant director of Wellness and Rehabilitation in compliance with existing hospital policy, EC.02.05.01.4.g Maintenance of Emergency Showers and Eyewash Stations, to ensure that it is present and functioning. Maintenance logs</p>				

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	<p>12:00 PM, review of MSDS titled: "MSDS Document Product Total Alkalinity Increaser, MSDS ID MSD92494, Manufacturer Haviland Consumer Products, Inc." revision date "01/15/2008," read: "First Aid Information...Eye Contact...Flush with large amount of water for at least 15 minutes..."</p> <p>5. In interview on 3-10-14 between 2:54 PM and 4:00 PM, Staff Member #L8 acknowledged the fire extinguishers stored on the floor in the purchasing storage area should have been stored securely.</p> <p>6. In interview on 3-13-14 between 11:00 AM and 12:00 PM, Staff Member #L9 acknowledged there was pool shock stored in a locker in the pool storage area for use in the pool and the pool room and pool storage area did not have an eyewash station for emergency use. Staff Member #L9 indicated the nearest eyewash station was located across the main hallway in a physician's office and to access the eyewash station, an employee would need to walk through a locker room, down the hall, through the rehabilitation waiting room, across a hallway, and into the physician office.</p>		<p>will be maintained in the department by Assistant Director of Wellness and Rehabilitation. Weekly testing and annual maintenance will be documented on the Emergency Shower/Eyewash Station Log. Auditing of the maintenance logs will be completed by the Facilities Manager monthly. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? Assistant Director of Wellness and Rehabilitation. 3.1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. All 8 gallon black waste containers were removed from their current location in the clean supply/medication rooms on all nursing units and placed in the Biohazard Soiled Utility Rooms on each nursing unit. This change was communicated to staff via email education by charge nurses by 04/14/2014. Signage was also placed in the clean supply/medication rooms by charge nurses to remind colleagues of the new location of pharmaceutical waste containers. Verbal communication via Charge Nurses during shift safety huddles was also used as a way to communicate this change 04/07/14 through 04/11/214. 2. How are you going to prevent the deficiency from recurring in the</p>		

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			<p>future? These waste containers will remain in the Biohazard Soiled Utility Rooms on each unit. The charge nurses will inspect the clean supply/ medication rooms daily to ensure that used patient care pharmaceutical supplies are not being disposed of or stored next to clean unused patient care supplies. If it is identified that dirty/used patient care pharmaceutical waste is being disposed of in the clean supply room the charge nurse will speak to the colleague responsible for mixing clean and dirty patient supplies. A documentation log was developed for use during daily inspections for charge nurses to monitor compliance with the new practice. The results of daily inspections will be shared with the Environment of Care Safety Coordinator and unit directors for a three month time period to enforce compliance. The results of the rounding will be shared by the Environment of Care Safety Coordinator at the monthly Environment of Care committee meetings. The goal will be set for 100 % compliance. If the goal is not met the unit director(s) will develop a Plan of Correction to meet the target. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The Environment of Care Safety Coordinator.NOW ADDRESSING SECOND TAG S11181.1. How</p>	

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			<p>are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. All 8 gallon black waste containers were removed from their current location in the clean supply/medication rooms on all nursing units and placed in the Biohazard Soiled Utility Rooms on each nursing unit. This change was communicated to staff via email education by charge nurses by 04/14/2014. Signage was also placed in the clean supply/medication rooms by charge nurses to remind colleagues of the new location of pharmaceutical waste containers. Verbal communication via Charge Nurses during shift safety huddles was also used as a way to communicate this change 04/07/14 through 04/11/214. 2. How are you going to prevent the deficiency from recurring in the future? These waste containers will remain in the Biohazard Soiled Utility Rooms on each unit. The charge nurses will inspect the clean supply/ medication rooms daily to ensure that used patient care pharmaceutical supplies are not being disposed of or stored next to clean unused patient care supplies. If it is identified that dirty/used patient care pharmaceutical waste is being disposed of in the clean supply room the charge nurse will speak</p>	

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			to the colleague responsible for mixing clean and dirty patient supplies. A documentation log was developed for use during daily inspections for charge nurses to monitor compliance with the new practice. The results of daily inspections will be shared with the Environment of Care Safety Coordinator and unit directors for a three month time period to enforce compliance. The results of the rounding will be shared by the Environment of Care Safety Coordinator at the monthly Environment of Care committee meetings. The goal will be set for 100 % compliance. If the goal is not met the unit director(s) will develop a Plan of Correction to meet the target. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The Environment of Care Safety Coordinator.2.1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The fluids being stored in the blanket warmer were removed on 03/14/2014 by the charge nurse. The blanket warmer was properly labeled on 04/04/14 by the charge nurse informing staff the blanket warmer cannot be used to be warm fluids. The proper warming of fluids was discussed along with existing hospital policy, F-3 Fluid Management and Warming, in safety huddle daily for one week	

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			<p>by the charge nurse from 04/08/14 through 04/11/2014. An educational email was sent out to nursing colleagues by the charge nurse providing accurate information on blanket warmer use and the proper warming of fluids on 04/08/14. 2. How are you going to prevent the deficiency from recurring in the future? A copy of the existing hospital policy, F-3 Fluid Management and Warming Daily, will be posted by the charge nurse in all areas that maintain warmers for colleagues to read and sign that they understand the expectations of fluid warming. This will be completed by 05/01/2014. The charge nurses will audit blanket warmers every day to ensure that blankets and fluids are not being kept in the same warming machine for three months to ensure compliance. Non-compliance will be addressed immediately by the charge nurse with the colleague involved. The findings of the audits will be shared at the monthly Environment of Care Committee by the EOCSC. Trends of non-compliance will be addressed with a POC by the unit director. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? Executive Director Med/Surg/Oncology</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>7. While on tour of the ICU/CCU on 3/12/14 at approximately 1200, accompanied by P3, the following was observed in the Medication/Clean Utility Room:</p> <p>A. two black pharmaceutical waste storage bins with used patient care pharmaceutical supplies were stored next to shelving units with clean unused patient care supplies.</p> <p>B. IV fluids were stored in the bottom compartment of the blanket warmer with blankets at a temperature of 112 degrees Fahrenheit (F).</p> <p>8. Document titled, "Pharmaceutical Waste Stream Management" indicated black pharmaceutical waste storage bins contain "hazardous Rx (pharmaceutical) waste".</p> <p>9. Policy No.: EQUIP-008, titled "Fluid</p>	S001118	<p>1.1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. On 3/14/2014 four obsolete extinguishers were removed from a purchasing storage area by the Environment of Care Safety Coordinator and disposed of appropriately. 2. How are you going to prevent the deficiency from recurring in the future? In the future any identified obsolete/expired extinguishers found on scheduled environmental rounds will be removed from the facility immediately upon discovery and disposed of appropriately by the Environment of Care Safety Coordinator. All spare or additional extinguishers will be secured by a strap or chain on a storage shelf in the purchasing area to hold and secure them in the upright position until they are needed or removed for</p>	05/01/2014			

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	<p>and Blanket Warmers" revised/reapproved 8/15/13, was reviewed on 3/12/14 at approximately 1:40 PM, and indicated on pg. 1, under Policy Statement section, points 1 and 4, "Fluids and blankets may not be warmed in the same warming machine...Fluids may not be warmed over a temperature of 104 degrees F".</p> <p>10. Personnel P3 was interviewed on 3/12/14 at approximately 1220 and confirmed the above-mentioned black pharmaceutical waste storage bins should be stored in the Soiled Utility room, not the Medication/Clean Utility Room; and IV fluids should not be stored with blankets in the same warmer above a temperature of 104 degrees F for patient and/or employee safety.</p>		<p>replacement.3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?The responsible person will be the Environment of Care Safety Coordinator.2.1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. A new permanent eyewash station was installed in the pool storage area on 04/14/2014 by the engineering department. All Lifeworks colleagues that work in the pool area were notified and educated on the new eyewash station by the Assistant Director of Wellness and Rehabilitation on 04/14/2014. A copy of the existing policy, EC.02.05.01.4.g Maintenance of Safety Showers and Eyewash Stations, was posted by the Assistant Director of Wellness and Rehabilitation on 04/14/2014 for colleagues working in the pool area to read and sign that they understand the expectation for the use of the eyewash station. 2. How are you going to prevent the deficiency from recurring in the future? A permanent eyewash station was installed on 04/14/2014 and will be checked weekly by the assistant director of Wellness and Rehabilitation in compliance with existing hospital policy, EC.02.05.01.4.g Maintenance of Emergency Showers and Eyewash Stations, to ensure that it is present and functioning. Maintenance logs</p>				

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			<p>will be maintained in the department by Assistant Director of Wellness and Rehabilitation. Weekly testing and annual maintenance will be documented on the Emergency Shower/Eyewash Station Log. Auditing of the maintenance logs will be completed by the Facilities Manager monthly. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? Assistant Director of Wellness and Rehabilitation. 3.1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. All 8 gallon black waste containers were removed from their current location in the clean supply/medication rooms on all nursing units and placed in the Biohazard Soiled Utility Rooms on each nursing unit. This change was communicated to staff via email education by charge nurses by 04/14/2014. Signage was also placed in the clean supply/medication rooms by charge nurses to remind colleagues of the new location of pharmaceutical waste containers. Verbal communication via Charge Nurses during shift safety huddles was also used as a way to communicate this change 04/07/14 through 04/11/214. 2. How are you going to prevent the deficiency from recurring in the</p>	

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			<p>future? These waste containers will remain in the Biohazard Soiled Utility Rooms on each unit. The charge nurses will inspect the clean supply/ medication rooms daily to ensure that used patient care pharmaceutical supplies are not being disposed of or stored next to clean unused patient care supplies. If it is identified that dirty/used patient care pharmaceutical waste is being disposed of in the clean supply room the charge nurse will speak to the colleague responsible for mixing clean and dirty patient supplies. A documentation log was developed for use during daily inspections for charge nurses to monitor compliance with the new practice. The results of daily inspections will be shared with the Environment of Care Safety Coordinator and unit directors for a three month time period to enforce compliance. The results of the rounding will be shared by the Environment of Care Safety Coordinator at the monthly Environment of Care committee meetings. The goal will be set for 100 % compliance. If the goal is not met the unit director(s) will develop a Plan of Correction to meet the target. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The Environment of Care Safety Coordinator.NOW ADDRESSING SECOND TAG S11181.1. How</p>	

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			<p>are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. All 8 gallon black waste containers were removed from their current location in the clean supply/medication rooms on all nursing units and placed in the Biohazard Soiled Utility Rooms on each nursing unit. This change was communicated to staff via email education by charge nurses by 04/14/2014. Signage was also placed in the clean supply/medication rooms by charge nurses to remind colleagues of the new location of pharmaceutical waste containers. Verbal communication via Charge Nurses during shift safety huddles was also used as a way to communicate this change 04/07/14 through 04/11/214. 2. How are you going to prevent the deficiency from recurring in the future? These waste containers will remain in the Biohazard Soiled Utility Rooms on each unit. The charge nurses will inspect the clean supply/ medication rooms daily to ensure that used patient care pharmaceutical supplies are not being disposed of or stored next to clean unused patient care supplies. If it is identified that dirty/used patient care pharmaceutical waste is being disposed of in the clean supply room the charge nurse will speak</p>	

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			to the colleague responsible for mixing clean and dirty patient supplies. A documentation log was developed for use during daily inspections for charge nurses to monitor compliance with the new practice. The results of daily inspections will be shared with the Environment of Care Safety Coordinator and unit directors for a three month time period to enforce compliance. The results of the rounding will be shared by the Environment of Care Safety Coordinator at the monthly Environment of Care committee meetings. The goal will be set for 100 % compliance. If the goal is not met the unit director(s) will develop a Plan of Correction to meet the target. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? The Environment of Care Safety Coordinator.2.1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The fluids being stored in the blanket warmer were removed on 03/14/2014 by the charge nurse. The blanket warmer was properly labeled on 04/04/14 by the charge nurse informing staff the blanket warmer cannot be used to be warm fluids. The proper warming of fluids was discussed along with existing hospital policy, F-3 Fluid Management and Warming, in safety huddle daily for one week	

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			<p>by the charge nurse from 04/08/14 through 04/11/2014. An educational email was sent out to nursing colleagues by the charge nurse providing accurate information on blanket warmer use and the proper warming of fluids on 04/08/14. 2. How are you going to prevent the deficiency from recurring in the future? A copy of the existing hospital policy, F-3 Fluid Management and Warming Daily, will be posted by the charge nurse in all areas that maintain warmers for colleagues to read and sign that they understand the expectations of fluid warming. This will be completed by 05/01/2014. The charge nurses will audit blanket warmers every day to ensure that blankets and fluids are not being kept in the same warming machine for three months to ensure compliance. Non-compliance will be addressed immediately by the charge nurse with the colleague involved. The findings of the audits will be shared at the monthly Environment of Care Committee by the EOCSC. Trends of non-compliance will be addressed with a POC by the unit director. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? Executive Director Med/Surg/Oncology</p>		