

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151332	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2011
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NAME OF PROVIDER OR SUPPLIER  DECATUR COUNTY MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 720 N LINCOLN ST GREENSBURG, IN 47240
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 004714</p> <p>Survey Date: 08/29-31/11</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Janelli Salomon-Angeles Medical Surveyor</p> <p>QA: claughlin 09/08/11</p> <p>12/14/11 revised due to IDR</p>	S0000		
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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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S0266	<p>410 IAC 15-1.4-1(a)(4)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(4) Review the bylaws at least triennially.</p> <p>Based on review of documents and interview, the governing board failed to follow hospital policy by not reviewing their bylaws at least annually.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of a hospital policy entitled Authentication of Policies Review of Documents indicated all policies must be ... reviewed and approved every year. It further indicated the Hospital Board of Trustees will be responsible for the authentication of Hospital Bylaws.</li> <li>2. Review of the governing board by-laws indicated they were last reviewed by the governing board on 9-25-08.</li> <li>3. On 8-30-11 at 2:30 pm, employee #A1 was requested to provided more recent documentation of governing by-law approval and none was provided prior to exit.</li> </ol>	S0266	<p>Tag # S 266 The deficiency was corrected by: The Decatur County Memorial Hospital Bylaws were reviewed by the Hospital Board on September 22, 2011. The Board will receive notification annually at the June Board meeting that the Bylaws are due for annual review at the September Board meeting. In the future the September Board meeting agenda will list the review and approval of the Board Bylaws as an agenda item. Responsible persons for the plan of correction: the Hospital Board Chairperson</p>	09/22/2011			

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S0310	<p>410 IAC 15-1.4-1(c)(6)(C)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(C) Ensuring that all health care workers, including contract and agency personnel, for whom a license, registration, or certification is required, maintain current license, registration, or certification and keep documentation of same so that it can be made available within a reasonable period of time.</p> <p>Based on review of documents and interview, the hospital failed to maintain a current license/certification for 1 of 10 health care worker files reviewed for whom a license/certification was required.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of a hospital job description for a Medical Technologist approved 11-20-07 indicated registration as Medical Technologist or equivalent required.</li> <li>2. Review of 10 health care worker files for whom a license or certification was required, indicated file PF#5 contained documentation as a certified medical</li> </ol>	S0310	<p>Tag # S 310</p> <p>The deficiency was corrected 9/19/2011 the medical technologist produced her license and Human Resources verified through the AMT website that her license has been active since 10/30/2008 and expires 11/1/2011. A copy was placed in her employee file.</p> <p>To prevent a reoccurrence the following action was taken: The information has been entered in the electronic file. Human Resources will run an annual license check report; the HR Assistant will add this step to her "new hire" checklist for all clinical employees. The HR Assistant will verify all certifications and licenses prior to the expiration date. An employee who requires</p>	09/19/2011	

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	<p>Technologist ending 10-31-09.</p> <p>3. On 8-31-11 at 2:45 pm, employee #A1 was requested to provide documentation of current certification on file PF#5 and no documentation was provided prior to exit.</p>		<p>a license will be suspended from work if their license has expired. The responsibility person will be the HR Assistant and the VP Support Services.</p>	

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S0406	<p>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.</p> <p>Based on document review and interview, the hospital failed to include 6 services directly-provided by the hospital and 5 services provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program. Additionally, the hospital failed to report 1 directly-provided service and 3 contracted services through its QAPI process.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include the directly-provided service of housekeeping, laundry, and the offsite facilities of DCMH Diagnostic Center, Tree City Medical Partners, Westport Clinic and Decatur Primary Care, and the contracted services of biohazardous waste, offsite housekeeping, telepsych and teleradiology.</p>	S0406	<p>Tag # S 406</p> <p>The Performance Improvement Program has been revised to include the following:</p> <ul style="list-style-type: none"> <li>Housekeeping – Patient room cleaning inspections</li> <li>Laundry – Weight of laundry washed compared to patient census</li> <li>Diagnostic Center – Monitor for mislabeling of specimens</li> <li>Tree City Medical Partners – Drug Storage inspection for out dated medication, and accurate inventory</li> <li>Decatur Primary Care – Monitor drug and supply storage areas for expired items</li> <li>Maintenance – Monitor and reduce energy consumption by 20% from baseline</li> <li>Contracted Services:</li> <li>Biohazardous waste – Monitor amount of waste compared to storage space</li> <li>Electromyography - Tag # S 406</li> <li>1. Decatur County Memorial</li> </ul>	09/22/2011	

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	<p>2. Further review of the facility's QAPI program indicated the hospital had criteria, standards and outcomes for the directly-provided service of maintenance, the contracted services of blood bank, pharmacy and wound care, but did not report the data, outcomes and action plans through its QAPI process.</p> <p>3. On 8-31-11 at 2:45 pm, upon interview, employee #A1 indicated there was no documentation of the above items and no documentation was provided prior to exit.</p>		<p>Hospital disputes the inclusion of electromyography as a contracted service. A physician, employed by the Hospital, provides electromyography in his office for his private patients only. He does not contract with the hospital to provide electromyography services to any other patient.</p> <p>Off site Housekeeping – Monitor tenant's survey for cleanliness. Telepsych – Monitor Problems with service, i.e., availability, response time.</p> <p>Teleradiology – Monitor for accuracy of readings Blood Bank- Monitor South Bend Reference lab for services provide per Contract and current certifications Pharmacy – Monitor timeliness and accuracy of medication orders processed by after hours pharmacy Wound Care –Healing rate Responsible person: Director of Performance Improvement and VP Quality Management/Compliance</p>		

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S0408	<p>410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</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>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).</p> <p>Based on document review and interview, the hospital failed to include reporting the activity of responses to patient emergencies (Code Blue) through its quality assurance and performance improvement (QAPI) process.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated the facility reported review of outcomes and action plans of responses to patient emergencies (Code Blue) but did not include reporting this activity through its QAPI process.</p> <p>2. On 8-31-11 at 2:45 pm, employee #A1</p>	S0408	<p>The deficiency will be corrected by reporting Code 99 and Rapid Response Team evaluations to the Performance Improvement committee via the PI Report. The information will then go forward to the Board for their review. To prevent the deficiency from reoccurring data will be added by the PI director on a quarterly basis. Responsible person: Director of PI</p>	09/19/2011
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	was requested to provide documentation of the reporting of the above function through its QAPI process. Upon interview, the employee indicated there was no documentation of this reporting and no other documentation was provided prior to exit.			
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S0596	<p>410 IAC 15-1.5-2(f)(3)(D)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and interview, the facility failed to follow manufacturer's recommendations for preparing cleaning solutions for surgical instruments in 1 Surgery Department.</p> <p>Findings include:</p> <p>1. Review of the manufacturer's recommendations for the Metrizyme enzymatic cleaner indicates the following: "1 ounce of Metrizyme per 1 gallon of water."</p> <p>2. On 08-30-11 at 1335 hours, staff #50 confirmed that he/she uses 3 pumps/ounces of Metrizyme to 6 gallons of water.</p> <p>3. On 08-30-11 at 1340 hours, staff #51</p>	S0596	<p>Tag # 596</p> <p>The deficiency was corrected by:</p> <p>1. Updated all surgery policies to identify the cleaning solution to be used and the manufacturer's recommendations regarding Metrizyme enzymatic cleaner - 1 oz Metrizyme to one (1) gallon of water.</p> <ul style="list-style-type: none"> <li>· OR: Care of Instruments, Scopes, Powered Instruments</li> <li>· OR: Care of Surgical &amp; Anesthesia Supplies, Clean Up Room</li> <li>· C.S - Standard of Practice, Attire, Sterilization and Disinfection</li> </ul> <p>To ensure that the deficiency does not reoccur the following was done:</p> <p>1. Staff education provided Wednesday, August 31 st</p> <ul style="list-style-type: none"> <li>· The importance of following manufacturer's recommendation regarding cleaning solutions.</li> </ul>	08/31/2011
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	confirmed that he/she mixes the Metrizyme cleaner with water based on color of water and solution.		<ul style="list-style-type: none"> <li>· Recommended Metrizyme 1 oz to 1 gallon of water.</li> <li>· Containers and sinks were marked with tape to distinguish gallon increments for correct preparation of the Metrizyme.</li> <li>· One pump of Metrizyme is equivalent to 1 oz.</li> <li>· Signs were posted above sinks with instructions for preparing the cleaning solution.</li> <li>1. E-mail sent to all clinical directors to recommend that they review their policies for cleaning solution preparation and follow manufacturer's recommendations for preparation.</li> </ul> <p>The responsible person is the OR/Ambulatory Services Director Completion: August 31, 2011</p>		

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S1020	<p>410 IAC 15-1.5-7 (d)(2)(A)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(A) Separation of drugs designed for external use from drugs intended for internal use.</p> <p>Based on document review and interview, the hospital failed to follow its policy to ensure the monthly inspection of 3 areas where drugs are stored.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled Drug Storage Areas indicated Off-site locations will be inspected with results documented each month by personnel designated by manager/supervisor/Director of off-site area.</p> <p>2. Hospital staff was requested to provide documentation of monthly drug storage areas at the Tree City offsite for the months of March, April and May, 2011.</p> <p>3. Hospital staff presented documents for monthly inspection of 3 areas at that off-site which contained medications,</p>	S1020	<p>Tag # S 1020 The deficiency will be corrected by: 1. Tree City Medical Partners will not receive or dispense sample drugs from October 3 through October 15. Samples will be logged via an inventory effective 9-30-11. 2. The sample drug storage and inventory policy and procedure will be revised. 3. Tree City Medical Partners staff will be trained on the policy and procedure for drug storage area inspections. 4. The drug storage area will be inspected monthly by the appropriate staff. 5. The Director of Pharmacy will monitor receipt of the inspection data. 6. Any delay in the receipt of the monthly inspection report will result in a deficiency report to the President/CEO 7. Failure to report inspections or discovered discrepancy in drug inventories will result in disciplinary action. Responsible person: Tree City Medical Partners Office Administrator and Director of</p>	09/30/2011
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	<p>each for the months of March, April and August, 2011.</p> <p>4. On 8-31-11 1:30 pm, employee #A1 was requested to provide documentation of the 3 monthly drug storage areas at the Tree City offsite and upon interview, the employee indicated there were none for the month of May, 2011.</p> <p>5. No other documentation for inspections at the 3 offsite locations for the month of May, 2011 were provided prior to exit.</p>		Pharmacy Completion date: October 15, 2011		

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S1022	<p>410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions.</p> <p>Based on document review and observation, hospital staff failed to follow hospital policy to appropriately store medications in 2 instances.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled Drug Storage Areas indicated medication refrigerators and freezers should be labeled with 'Medication Only' to communicate that food and other are not allowed.</p> <p>2. On 8-30-11 at 11:50 am, in the presence of employee #A6, it was observed in the Vaccine Dosage Room of the Immunology Clinic at the Tree City offsite, there were 2 refrigerators in which vaccine medications were stored.</p> <p>3. It was observed a white refrigerator had a sign on it which indicated Drug Storage <u>ONLY</u>, No Food or Dink or Lab</p>	S1022	<p>Tag # S 1022</p> <p>The deficiency was corrected by the labeling of the "water bottles" required to be in refrigerator used for vaccine storage as not for drinking. All bottles except those labeled as "water not for drinking" were removed from the vaccine refrigerator. The Infection Prevention nurse and the pharmacy technicians will monitor the refrigerator for bottles not properly labeled. The drug refrigerators will be monitored for any items other than pharmaceuticals by the pharmacy technicians and clinic staff.</p> <p>Responsible person: Tree City Medical Partners Office Administrator and Director of Pharmacy</p> <p>Completion date: September 22, 2011</p>	09/22/2011
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	<p>Specimens. On the inside of the refrigerator were 4 0.5 liter bottles of Ice Mountain drinking water. There was also a 2 liter green bottle with liquid in it, labeled Sprite. It was also observed there were several vaccine medications in the refrigerator.</p> <p>4. It was also observed there was a second stainless steel refrigerator had a sign on it which indicated Drugs Only No Food. On the inside of the refrigerator were 2 0.5 liter bottles labeled of drinking water.</p>			
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NAME OF PROVIDER OR SUPPLIER  DECATUR COUNTY MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 720 N LINCOLN ST GREENSBURG, IN 47240		
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S1114	<p>410 IAC 15-1.5-8 (b)(1)</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>(1) No condition in the facility or on the grounds shall be maintained which may be conducive to the harborage or breeding of insects, rodents, or other vermin.</p> <p>Based on observation, the hospital created 1 condition in the facility which was conducive to the harborage of insects.</p> <p>Findings:</p> <p>1. On 8-29-11 at 2:05 pm, in the presence of employes #A4 and #A6, it was observed in a storage room in the Laboratory there were 2 ceiling light fixtures, each which contained a numerous amount of dead insects.</p>	S1114	<p>Tag # S 1114</p> <p>The light fixture was cleaned on September 1, 2011.</p> <p>To prevent a reoccurrence the inspection of all lighting fixtures was added to the monthly Safety Risk Assessment Form which is completed by Department Directors and reported to the Safety Committee.</p> <p>Responsible person: Director of Facilities.</p>	09/01/2011	

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S1118	<p>410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, interview and observation, the hospital failed to follow its policy and created conditions which resulted in a hazard to patients, public or employees in 3 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of a hospital policy entitled Medical Gases (definition) indicated all pressurized gas cylinders will be secured at all times whether full or empty.</li> <li>On 8-29-11 at 3:05 pm in the presence of employee #A6, it was observed in the maintenance shop, there were 10 fire extinguishers (gas cylinders) on a shelf unsecured by chain or holder.</li> <li>If any of the above extinguishers were knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</li> </ol>	S1118	<p>Tag # S 1118 1-3 Secured Fire Extinguishers by repairing the latch installed on the chain. Gas cylinders being securely fastened is listed on the monthly Safety Risk Assessment Form. Monitoring will be done by the Safety Committee. Completion date: September 1, 2011</p> <p>Responsible person: Director of Facilities 4-6 Policy/procedure was revised to include time frame and also requirement to report finds to caller. Maintenance staff was educated to policy revisions. To prevent reoccurrence the Facilities Director will initiate an emergency test call monthly times 3 then quarterly. Completion date: September 15, 2011</p> <p>Responsible person: Director of Facilities 7-10 Review locations including kitchen area where caustic material is used for installation of permanent eyewash stations and order equipment as necessary. Completion date: 9/30/2011</p>	09/15/2011			

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	<p>4. Review of a hospital policy entitled Work Requisitions indicated [for work orders], phone calls are not to be made except in cases of emergencies.</p> <p>5. On 8-29-11 at 11:23 am in the presence of employee #A6, it was observed there was a telephone call made by hospital staff indicating the negative pressure room was not operating properly; i.e. an emergency.</p> <p>6. On that same date and time, upon interview, employee #A6 indicated a hospital maintenance staff worker should appear to respond to the telephone request within 6-20 minutes. By 11:43 am (20 minutes later), there was no appearance by a hospital maintenance staff worker in response to the emergency telephone call request.</p> <p>7. During tour of the kitchen on 8/29/2011 at 11:30 am, two bottled containers of solutions were observed mounted on the wall, labeled "Eyewash".</p> <p>8. In review on 8/29/2011 at 11:30 am, the Material Safety Data Sheet (MSDS) for the Oasis 146 Multi-Quat Sanitizer in use for sanitizing kitchen surfaces read: "Avoid contact with eyes. Wash thoroughly after handling." and "Provide</p>		<p>Installation of permanent eye wash stations in all required area Completion date: October 30, 201 Responsible person: Director of Facilities</p>	

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	<p>suitable facilities for quick drenching or flushing of the eyes and body in case of contact or splash hazard.</p> <p>9. In review, the Occupational Safety and Health Administration (OSHA) regulation at 29 CFR 1920.151(c) read, "Where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use." The American National Standards Institute (ANSI) at Z358.1 is the recognized source of guidance to comply with OSHA 1910.151(c) which requires that eyewash units need to be able to sustain a water flow for a minimum of 15 minutes in order to ensure that the casutic material has been removed.</p> <p>10. In interview on 8/29/2011 at 11:30 am, staff member #A1 acknowledged that the squirt bottles would not be able to provide the required 15 minutes continuous water flow to the eyes.</p>			

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S1162	<p>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:</p> <p>(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 interview, the hospital failed to document annual preventive maintenance (PM) of 1 piece of equipment in accordance with the manufacturer's recommended maintenance schedule.</p> <p>Findings:</p> <p>1. On 8-29-11 at 10:00 am, employee #A4 was requested to provide documentation of PM on the facility's laundry washer.</p> <p>2. On 8-31-11 at 11:40 am, upon interview, employee #A6 indicated there was no documentation of PM on the above equipment and no documentation was provided prior to exit.</p>	S1162	<p>Tag # S 1162</p> <p>Maintenance staff has performed preventive maintenance per manufacturer on the laundry equipment. Completed: September 15, 2011</p> <p>To prevent a reoccurrence the laundry equipment has been added to the PM Asset list for annual maintenance.</p> <p>Responsible person: Director of Facilities</p> <p>Completion date: September 15, 2011</p>	09/15/2011	

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S1164	<p>410 IAC 15-1.5-8(d)(2)(B)</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>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and interview, the hospital failed to document annual preventive maintenance (PM) of 2 pieces of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 8-29-11 10:00 am, employee #A4 was requested to provide documentation of PM on a laundry washing machine and the overhead paging system used to communicate a Code Blue situation.</li> <li>On 8-31-11 at 11:40 am, upon interview, employee #A6 indicated there was no documentation of PM on the laundry washing machine and no documentation was provided prior to exit.</li> <li>On 8-31-11 at 2:55 pm, upon interview, employee #A6 indicated there was no documentation of PM on the overhead paging system used to</li> </ol>	S1164	<p>Tag # S 1164</p> <p>The deficiency was corrected by the Maintenance Staff has performed preventive maintenance per manufacturer on the laundry equipment. Completed: September 15, 2011</p> <p>To prevent a reoccurrence the laundry equipment has been added to the PM Asset list for annual maintenance. Responsible person: Director of Facilities Completion date: September 15, 2011</p> <p>The deficiency has been corrected by testing of the paging and telephone systems. Completed by September 15, 2011</p> <p>To prevent a reoccurrence the functioning of the paging system and telephone have been added to fire drill critique sheet. These systems are to be considered PM'd if they work properly during fire drills. Documentation will be quarterly.</p>	09/15/2011

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	communicate a Code Blue situation and no documentation was provided prior to exit.		Completion date: September 15, 2011. Responsible person: Director of Facilities	
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S1168	<p>410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on document review and interview, the hospital failed to follow its policy to properly keep a discharge log for 1 of 1 defibrillators.</p> <p>Findings:</p> <p>1. Review of a hospital policy entitled Crash Cart Check/Defibrillator Check indicated defibrillators will be discharged according to manufacturer's recommendation once a day during normal business hours for the department.</p> <p>2. Review of a document entitled LifePak 20 Defibrillator/Monitor <u>Daily</u> Check-Off, for the time period August 1 through August 30, 2011, indicated there were no required checks (since the defibrillator was accessible to hospital personnel 24 hours a day, 7 days a week) on August 6, 7, 13, 14, 20, 21, 27 and 28.</p> <p>3. On 8-30-11 at 10:30 am, in the presence of employee #A6, upon interview, a hospital staff member of the</p>	S1168	<p>Tag # 1168 The deficiency was corrected by the Cardiac and Pulmonary Rehabilitation (CR/PR) Department staff locking the LifePak 20 Defibrillator in the CR/PR office at the end of business each Friday and the last working day before each holiday as the department is not open on weekends or holidays. The Defibrillator will be replaced on the Crash Cart at the beginning of the first day that the department is open again. The Defibrillator will continue to be checked and discharged once a day during normal business hours on days the department is open and staffed. To prevent the deficiency from occurring again, the CR/PR rehab staff will fill out the LifePak 20 Defibrillator/Monitor Check-Off Record each weekend/holiday indicating that the Defibrillator was locked in the CR/PR office on days the department is not open. The CR/PR staff will be responsible for locking the LifePak 20 Defibrillator in the CR/PR office before each day that the department is not open. Responsible person: CR/PR</p>	09/30/2011
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	Cardio Rehab department indicated the department was open Monday through Friday during normal business hours, but not staffed on weekends. The employee also indicated the defibrillator in the department was accessible to hospital personnel 24 hours a day, 7 days a week.		Manager Completion date: September 30, 2011.		

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S1186	<p>410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with NFPA 101 Life Safety Code, 2000 at its 4 offsite facilities.</p> <p>Findings:</p> <p>1. NFPA 101 Life Safety Code, 2000 Edition, indicated fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.</p> <p>2. Review of fire drills conducted at the 4 offsite facilities for year 2010, were as follows:</p>	S1186	<p>Tag # 1186</p> <p>The deficiency was corrected by each off-site facility conducting a fire drill.</p> <p>To prevent a reoccurrence the manager of each off site location will be responsible to conduct a fire drill at least quarterly and complete a fire drill compliance check list for each drill. The check list will be collected by the Safety Officer. The Safety Committee will be responsible for monitoring for compliance.</p> <p>Date of Completion: September 15, 2011 Responsible person: Managers</p>	09/15/2011
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	<p>Westport - no fire drill in 4th quarter Primary Care -no fire drill in all 4 quarters Tree City - no fire drill in 1st, 2nd and 4th quarter DCMH-Dx Center - no fire drill in all 4 quarters</p> <p>3. On 8-31-11 at 11:45 am, employee #A6, upon interview, indicated there were no fire drills conducted as appears, above and no further documentation was provided prior to exit.</p>		of Off Site Facilities and the Safety Officer.		