

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151302	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN 47348
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S000000	<p>The visit was for a Licensure survey.</p> <p>Facility Number: 005101</p> <p>Survey Date: 7-22-13 and 7-23-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Steve Poore, BS, MLT Medical Surveyor 3</p> <p>QA: claughlin 07/31/13</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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S000606	<p>410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. Based on document review, personnel health file review, and interview, the infection control committee failed to ensure an effective infection control program related to the immune status of employees by neglecting to evaluate and monitor personnel immune status for communicable diseases (Rubella, Rubeola, and Varicella) for 13 of 21 staff files reviewed and rubella, rubeola, varicella and hepatitis B) for 8 of 10 staff files reviewed.</p> <p>1. The November 25, 2011 Centers for Disease Control and Prevention (CDC) publication titled Immunization of Health-Care Personnel (HCP)</p>	S000606	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The process for new hires will change, beginning 08/19/2013. New employees will receive instructions for pre-employment blood work , including, Rubella Titer, Rubeola Titer, Varicella Titer, Urine Drug Screen, Mumps IgG, and HBs AB Titer (done on anyone who has had Hepatitis B series). The results of this blood work will be discussed at the employee's pre-employment physical. New employees will be given instructions on obtaining the needed immunizations based on these results. The new employee will not be allowed to</p>	02/17/2014

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	<p>Recommendations of the Advisory Committee on Immunization Practices (ACIP) indicated the following: " Varicella: Criteria for evidence of immunity to varicella were established. For HCP they include written documentation with 2 doses of vaccine, laboratory evidence of immunity or laboratory confirmation of disease, diagnosis of history of varicella disease by health-care provider, or diagnosis of history of herpes zoster by health-care provider ... "</p> <p>2. Personnel files for 8 of 10 personnel (staff A3, P1, P2, P3, P4, P5, P6, P7 and P8) indicated self-reporting for a history of disease to Varicella and lacked documentation of laboratory evidence of immunity or diagnosis by a health-care provider.</p> <p>3. Personnel file review for 5 of 11 nursing staff files indicated:</p> <p>a. CST (certified surgical tech) N1 was hired 11/19/12 and had a Rubella titer that read "Equivocal" and that the Rubella "Antibody [was] Not Detected"</p> <p>b. CNA (nursing assistant) N2 was hired 12/10/12 and had a Rubella titer that read "Equivocal" and that the Rubella "Antibody [was] Not Detected"</p> <p>c. RN (registered nurse) N8 was hired 6/18/12 and had documentation of one</p>		<p>report to work until the required immunizations are obtained. (see attachment TAG # 606-A, TAG # 606-B, and TAG # 606-C) All current employees who have missing documentation and/or titer screening will receive a letter from the IU Health Blackford Hospital Employee Health Nurse with instructions to complete documentation and/or receive needed titer. (see attachment TAG # 606 – D) Employees who have not responded within 30 business days from the date of the letter will not be allowed to return to work until completion of all required documentation, titers, and immunizations. Employee files will be reviewed in batches of ten. The letters generated by the review of the first ten will be mailed to employees on 08/19/2013. Every two weeks ten additional employee files will be reviewed. This process will continue until all employee files are reviewed and updated. Employee Health will monitor the new employee health files as a Quality Indicator for completing required titers and immunizations. The Process Improvement monitoring will begin 09/01/2013.2. How are you going to prevent the deficiency from recurring in the future? The improved process for new hires will prevent new employees from beginning work until all titers, immunizations, and documentation is complete. 3.</p>				

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	<p>MMR (measles, mumps, rubella immunization) on 2/20/02 and a Rubeola titer of 6/7/12 that was negative for immunity</p> <p>d. Staff members N9 and N11 had a self reported history of disease for Varicella</p> <p>4. interview with staff member #56, the employee health nurse, at 1415 hours on 7/23/13 indicated:</p> <p>a. this facility hasn't yet put into place any follow up for those staff hired giving a verbal report of history of Varicella--it may be in the budget in 2014</p> <p>b. with verbal history reporting, it is unknown if staff members N9 and N11 are at risk during an outbreak of Chicken pox</p> <p>c. it was unknown that an equivocal titer meant that the immune status was unknown and should be considered negative for antibody/immunity, specifically for N1 and N2</p> <p>d. it was not clear that N8 had a negative Rubeola--this was missed at the time of hire</p> <p>5. interview with staff member #61, the infection preventionist, at 1555 hours indicated:</p> <p>a. it was unknown that an equivocal titer meant that the immune status was</p>		<p>Who is going to be responsible for numbers 1 and 2? Jan Cansler, RN, Employee Health Nurse and Kandi Adamson, CNO4. By what date are you going to have the deficiency corrected? (month, day, year) (may use 30 day increments) The process change for new hires will begin on 08/19/2013. The review of current employee files will begin on 08/12/2013. Employee files will be reviewed in batches of ten. The letters generated by the review of the first ten will be mailed to employees on 08/19/2013. Every two weeks ten additional employee files will be reviewed. This process will continue until all employee files are reviewed and updated. The completion date for all employee files to be reviewed and updated is 02/17/2014.</p>		

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	<p>unknown and should be considered negative for antibody/immunity, specifically for N1 and N2</p> <p>b. it was not clear that N8 had a negative Rubeola--this was missed at the time of hire</p> <p>c. based on information from health files, as written in 3. above, the infection control program, as relates to employee health, is ineffective</p> <p>6. During an interview on 7-23-13 at 1445 hours, staff A16 confirmed that the 8 personnel files lacked laboratory evidence of immunity to Varicella or diagnosis by a health-care provider.</p> <p>7. Personnel files for 8 of 10 personnel (staff A3, P1, P2, P3, P4, P5, P6, P7 and P8) indicated self-reporting for a history of disease to varicella and lacked documentation of laboratory evidence of immunity or diagnosis by a health-care provider.</p> <p>8. During an interview on 7-23-13 at 1445 hours, staff A16 confirmed that the 8 personnel files lacked laboratory evidence of immunity to varicella or diagnosis by a health-care provider.</p>						

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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 policy and procedure review, document review, medical record review, observation, and staff interview, the nursing executive failed to ensure the implementation of policies related</p>	S000912	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. (A) The Emergency Department staff and the Dietary staff will receive</p>	08/23/2013

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	<p>to: refrigerator temperature checks, contacting IOPO (Indiana Organ Procurement Organization), and fall risk assessments.</p> <p>Findings:</p> <p>1. at 3:55 PM on 7/22/13, review of the policy and procedure "Refrigerator Temperature", policy number ME-6, with a most recent approved date of 1/13, indicated:</p> <p>a. under "Procedure", it reads: "...2. Refrigerator temperature will be kept...and between 34 [degrees] F and 38 [degrees] F for food..."</p> <p>2. at 2:05 PM on 7/22/13, while on tour of the ED (emergency department) in the company of staff members #50, the chief nursing officer, and #56, the ED nursing manager, it was observed that the temperature log on the pantry refrigerator indicated:</p> <p>a. there was no temperature range listed on the page to alert staff if the refrigerator temperature was not within the appropriate margins</p> <p>b. there were 6 days between July 1, 2013 and July 22, 2013 that the temperature was not in the 34 to 38 degree range expected per facility policy, or not checked at all</p> <p>3. interview with staff member #50, the</p>		<p>additional education on the "Refrigerator Temperature" policy and use of the Refrigerator/Freezer Temperature Record. (See attachment TAG # 192-A and TAG # 192-B)The Emergency Department will use the correct record, which indicates the acceptable temperatures for refrigerators storing patient food, refrigerators storing medication, and freezers. The use of the Refrigerator/Freezer Temperature Record has been established as a Quality Indicator for the Dietary Department effective August 1, 2013. (B) The policy "Death of a Patient" was revised to include documentation requirements in the electronic medical record and on paper when the electronic medical record is not available. (See attachment TAG # 192-C)The Medical/Surgical staff will receive education on the policy revision and expectation for documentation. <i>NOTE: The Summary Statement of Deficiencies states, "pt. #5 died on 5/18/13 and lacked documentation of contact with IOPO" Compliance with death notification to IOPO for May 2013 is 100%. This indicates that IOPO was notified but the patient's medical record lacks documentation of the notification. Documentation on the Notice of Death form in the electronic medical record and/or the paper form Expired Patient</i></p>		

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	<p>chief nursing officer, at 3:55 PM on 7/22/13 indicated the nursing staff in the ED were not utilizing the appropriate temperature log (which does note the acceptable refrigerator temperature range for pantry refrigerators)</p> <p>4. at 3:40 PM on 7/23/13, review of the policy and procedure "Death of a Patient", no policy number, with a last approval date of 12/12, indicated:</p> <p>a. under the section "Pronouncement of Death", it reads: "...5. Call IOPO...a. Call IOPO for ALL deaths..."</p> <p>5. review of patient death records at 11:40 AM on 7/23/13, indicated 1 of 3 patients who died at the facility lacked documentation that nursing staff contacted IOPO, as required by facility policy, as follows:</p> <p>a. pt. #5 died on 5/18/13 and lacked documentation of contact with IOPO</p> <p>6. interview with staff member #59, the RN (registered nurse) who "reviews mortalities" at the facility, at 12:45 PM on 7/23/13, indicated:</p> <p>a. "for a while staff was putting death information into different places" in the medical record</p> <p>b. there is no documentation in the medical record that would indicate nursing staff contacted IOPO after the</p>		<p>Documentation Sheet has been established as a Quality Indicator for the Medical/Surgical Department effective August 1, 2013. (C)The IU Health System changed the fall assessment tool in the electronic medical record to the Johns Hopkins fall scoring tool at the end of February 2013. The Medical/Surgical Department received training for the use of this tool on 02/20/2013 and again at yearly nursing competency on 04/04-24/2013. At the time of the change in the electronic medical record the IU Health System policy was not available for the staff. The IU Health System policy "Adult Inpatient Fall Prevention" replaced the IU Health Blackford policy "Fall Prevention Program" policy on 08/09/2013. (See attachment TAG # 192-D)The system policy matches the Johns Hopkins fall scoring tool that is used for inpatients in the electronic medical record. Education for the Medical/Surgical staff took place initially on 02/20/2013 and 04/04-24/2014 for the changes in the electronic medical record. Education for the Medical/Surgical staff on the IU Health System policy "Adult Inpatient Fall Prevention" took place on 08/09/2013.2. How are you going to prevent the deficiency from recurring in the future? (A) The Emergency Department staff and Dietary Department staff will receive</p>				

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	<p>death of pt. #5</p> <p>7. at 3:05 PM on 7/23/13, interview with staff member #62, RN assisting with on line medical record review, indicated:</p> <p>a. it is thought that the nurse caring for pt. #5 at the time of death was a "relatively new nurse who thought the house supervisor did that" (contacting IOPO and documenting in the medical record)</p> <p>8. at 2:15 PM on 7/22/13, review of the policy and procedure "Fall Prevention Program", no policy number, with a last approved date of 3/12, indicated:</p> <p>a. under "Procedure", it reads: "Patient Fall Risk Assessment 1. Med/Surg and ED patients will be assessed and monitored using the Hendrich II Fall Risk Scale. Criteria used to determine a patient's Hendrich II Fall Scale Score:..."</p> <p>9. at 3:15 PM on 7/22/13, review of the facility "Quality Council" meeting minutes for 2012 and 2013 indicated:</p> <p>a. the 2/15/13 meeting indicated the facility would begin using the Johns Hopkins fall scoring tool on 2/28/13</p> <p>10. at 11:15 AM on 7/23/13, interview with staff members #50, the chief</p>		<p>additional education during August 19 – 23, 2013. Old refrigerator logs were replaced with the appropriate Refrigerator/Freezer Temperature Record on July 23, 2013. Monitoring the Refrigerator/Freezer Temperature Record has been established as a Quality Indicator for the Dietary Department effective August 1, 2013.(B) Education with the Medical/Surgical Department staff on proper documentation of the death of a patient began August 9, 2013. Monitoring the documentation of the death of a patient has been established as a Quality Indicator for the Medical/Surgical Department effective August 1, 2013.(C) Implementation of the IU Health System policy "Adult Inpatient Fall Prevention" became effective on August 9, 2013. The policy now matches the assessment tool in the electronic medical record.3. Who is going to be responsible for numbers 1 and 2? (A) Jan Cansler, RN, Emergency Department Manager, Trisha Cameron, Dietary Manager, and Kandi Adamson, CNO.(B) Tim Williams, RN, Medical/Surgical Manager and Kandi Adamson, CNO.(C) Kandi Adamson, CNO</p> <p>4. By what date are you going to have the deficiency corrected? (month, day, year) (may use 30 day increments) (A) The Emergency Department and Dietary Department will receive</p>		

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	nursing officer, and #63, the RN Quality manager, indicated: a. the fall prevention policy approved 3/12 is no longer correct and does not follow current practice b. the corporate entity decided to use the Johns Hopkins tool and loaded it into the computer system (Cerner) the end of February 2013 c. there are many nursing managers who have been involved in the re-writing of the fall policy over the last few months d. it is unknown when the new policy, which will indicate the Johns Hopkins assessment will be utilized, will be complete e. at the present time, nursing staff is not following policy as they are using the new assessment tool f. policy should have been updated at the time of a change to the fall risk assessment tool		education 08/19-23/2013. The Performance Improvement monitoring began August 1, 2013. (B) The Medical/Surgical staff will received education on 08/09/2013. The Performance Improvement monitoring began August 1, 2013.(C) The education for the Medical/Surgical staff on the Johns Hopkins fall scoring tool took place initially on 2/20/2013 and 4/04-24/2013. The education for the Medical/Surgical staff on the IU Health System Adult Inpatient Fall Prevention policy took place on 08/09/2013.		

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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 policy and procedure review, document review, observation, and staff interview, the facility failed to ensure that no condition was maintained that could create a hazard for patients, staff, or visitors in three areas toured.</p> <p>Findings:</p> <p>1. at 8:45 AM on 7/23/13, review of the policy and procedure "Crash Cart Policy" (no number), with a last revised date of 12/12, indicated:</p> <p>a. under the section "Monthly Crash Cart Comprehensive Checks", it reads: "1. Each cart will be checked against the supply list each month. 2. Any item that is within one (1) month of expiring must be removed from the cart and replaced..."</p> <p>2. While on tour of the medical/surgical nursing unit at 1:20 PM on 7/22/13 in</p>	S001118	<p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. (A) The Medical/Surgical Department staff received additional education on 08/09/2013 and will receive education again on 08/28/2013 on the Crash Cart policy, including education to remove any item from the Crash Cart that is within one month of expiring. (See attachment TAG # 1118-A) Checking and removing outdated items from the Crash Cart became a Quality Improvement indicator for the Medical/Surgical Department effective August 1, 2013. The Medical/Surgical Department staff received education on 08/09/2013 and will receive education again on 08/28/2013 on the revised Crash Cart Supply Checklist. (See attachment TAG # 1118-B) Any item in the Crash Cart that has an expiration date will have</p>	08/09/2013			

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	<p>the company of staff members #50, the chief nursing officer, and #55, the med/surg nurse manager, it was observed in the crash cart that the following items were expired:</p> <ul style="list-style-type: none"> a. one IV (intravenous) start kit that expired 1/13 b. one IV start kit that expired 3/13 <p>3. interview with staff member #55, the nurse manager for the medical/surgical unit, at 1:25 PM on 7/22/13 indicated:</p> <ul style="list-style-type: none"> a. the monthly checklist for checking the crash cart is dated 7/18/13 (this was provided and reviewed) b. the IV start kits were missed as being expired during monthly checks since the first of the year <p>4. at 3:55 PM on 7/22/13, review of the policy and procedure "Refrigerator Temperature", policy number ME-6, with a most recent approved date of 1/13, indicated:</p> <ul style="list-style-type: none"> a. the policy only addresses refrigerator temperatures and does not address cleaning of pantry refrigerators <p>5. while on tour of the ED (emergency department) at 2:05 PM on 7/22/13, while in the company of staff members #56, the ED nurse manager, and #50, the chief nursing officer, it was observed that the patient refrigerator was found to</p>		<p>the date of expiration indicated on the checklist to ensure that items within one month of expiring will be removed from the cart and replaced as needed. (B) The Dietary Department policy "Ancillary Dietetic Services" was revised to include cleaning and documentation of the patient pantry refrigerators/freezers. (See attachment TAG # 1118-C) The Dietary Department received education on this policy revision on 08/09/2013. Cleaning patient pantry refrigerators/freezers and maintaining documentation became a Quality Improvement indicator for the Dietary Department effective August 1, 2013.(C) The Surgical Services Department policy "Warming Cabinet" was revised to include cleaning of the interior of the cabinet. (See attachment TAG # 1118-D)The cleaning of the warming cabinet was added to the weekly cleaning schedule for Surgical Services on 07/26/2013. Cleaning of the interior of the warming cabinet and maintaining documentation of the cleaning is became a Quality Indicator for the Surgical Services Department effective August 1, 2013. 2. How are you going to prevent the deficiency from recurring in the future? (A) The Medical/Surgical Department received additional education on 08/09/2013 and will receive education again on 08/28/2013 on the Crash Cart policy, including education to</p>				

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	<p>be especially dirty on the shelves of the door and under the vegetable drawers</p> <p>6. interview with staff member #56, the ED nurse manager, at 2:10 PM on 7/22/13 indicated:</p> <p>a. cleaning of the pantry refrigerator is not on a routine schedule</p> <p>b. it is unknown the last time the refrigerator was cleaned</p> <p>7. at 3:00 PM on 7/23/13, review of the policy and procedure "Warming Cabinet", (no policy number), with a last revised date of 10/12 indicated:</p> <p>a. under "Procedure", it reads in item "4.": "Cabinet surfaces may be cleaned with a Hospital approved disinfectant."</p> <p>b. the policy does not specifically address the cleaning of the interior of the cabinet(s)</p> <p>8. while on tour of the pre/post operative areas of the surgery department at 10:15 AM on 7/23/13, in the company of staff members #57, the surgery department manager, #61, the infection preventionist, and #50, the chief nursing officer, it was observed that there was an accumulation of dust in the top cabinet of the Amsco blanket warmer, under the lower shelf (plenum), that creates a possible infection hazard and a fire hazard</p>		<p>remove any item from the Crash Cart that is within one month of expiring. Checking and removing outdated items from the Crash Cart is a Quality Improvement indicator for the Medical/Surgical Department effective August 1, 2013. (B) The Dietary Department policy "Ancillary Dietetic Services" was revised to include cleaning and documentation of the patient pantry refrigerators/freezers. The Dietary Department received education on this policy revision on 08/09/2013. Cleaning patient pantry refrigerators/freezers and maintaining documentation is a Quality Improvement indicator for the Dietary Department effective August 1, 2013.(C) The Surgical Services Department policy "Warming Cabinet" was revised to include cleaning of the interior of the cabinet. The cleaning of the warming cabinet was added to the weekly cleaning schedule for Surgical Services on 07/26/2013. Cleaning of the interior of the warming cabinet and maintaining documentation of the cleaning is a Quality Improvement indicator for the Surgical Services Department effective August 1, 2013. 3. Who is going to be responsible for numbers 1 and 2? (A) Tim Williams RN, Medical/Surgical Nurse Manager and Kandi Adamson CNO. (B) Trisha Cameron, Dietary Department Manager and Kandi Adamson CNO. (C) Tobey Jones, RN, Surgical Services Manager</p>		

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S001168	<p>9. interview with staff member #57, the surgery manager, at 10:20 AM on 7/23/13, indicated:</p> <p>a. it was unknown that dust/lint from the blankets would cause a build up of dust under the lower shelf</p> <p>b. the blanket warmer is not on a cleaning schedule</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 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, observation and interview, the facility failed to ensure that defibrillator inspection and testing was performed according to the manufacturer's recommendations for 2 of 2 (one each Lifepak 12 and Zoll Series R) defibrillators.</p> <p>Findings:</p> <p>1. The Physio-Control LifePak 12</p>	S001168	<p>and Kandi Adamson CNO. 4. By what date are you going to have the deficiency corrected? (month, day, year) (may use 30 day increments) (A) Checking and removing outdated items on the Medical/Surgical Crash Cart, according to policy, took place on 08/09/2013.(B) Cleaning and documentation of the patient pantry refrigerators/freezers took place on 08/09/2013. (C) Cleaning and documentation of the warming cabinet in the Surgical Services Department took place on 07/26/2013.</p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The "Crash Cart" Policy was revised on 08/09/2013 to include instructions for both the Lifepak 12 defibrillator and the Zoll R Series defibrillator to be inspected and tested daily, according to the manufacturer's recommendations and specifications. (See attachment TAG # 1168-A) The "Crash Cart" Policy covers the</p>	08/09/2013			

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	<p>Operating Instructions (2008 edition) Appendix C indicated an Operators Checklist of manufacturer's recommendations for daily inspection and testing of the defibrillator. The checklist included the following provisions:</p> <p>A. inspect physical condition of the equipment including cables, cords, and connectors</p> <p>B. check therapy and ECG electrodes for expiration date and spare electrode availability</p> <p>C. performing User Test with either Quick Combo therapy cable and test load or Hard Paddles User Test</p> <p>2. The Zoll R Series Operator 's Guide (2012 edition) Chapter 12 Maintenance indicated an Operators Checklist for R Series Products recommendations for daily inspection and testing of the defibrillator. The checklist included the following provisions:</p> <p>A. performing a daily visual inspection of the equipment including cables, cords, and connectors</p> <p>B. checking the hands-free therapy electrodes in sealed packages - 2 sets</p> <p>C. manual defibrillator discharge testing using hands-free therapy electrodes and 30 Joules energy</p> <p>3. The policy/procedure Crash Cart</p>		<p>Medical/Surgical Department, Emergency Department, and Surgical Services Department Crash Carts. The document "Daily Crash Cart Checklist" was replaced with a "Crash Cart Check Sheet" that requires daily inspections, according to the manufacturer's operator's checklist. Staff education on the Crash Cart Policy and Crash Cart Check Sheet began 08/09/2013. (See attachment TAG 1168-C)2. How are you going to prevent the deficiency from recurring in the future? Education on the Crash Cart Policy and the Crash Cart Check Sheet began on 08/09/2013 for the Medical/Surgical Department, Emergency Department, and Surgical Services Department staff.3. Who is going to be responsible for numbers 1 and 2? Jan Cansler, RN, Emergency Department Manager, Tim Williams, RN, Medical/Surgical Department Manager, Tobey Jones, RN, Surgical Services Manager, And Kandi Adamson, CNO.4. By what date are you going to have the deficiency corrected? (month, day, year) (may use 30 day increments) The Crash Cart policy was revised on 08/09/2013. The Crash Cart Check Sheet was revised on 08/09/2013. Staff education took place on 08/09/2013.</p>				

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	<p>Policy (approved 12-12) lacked a provision for performing defibrillator operational checks in accordance with the manufacturer recommendations.</p> <p>4. During a tour of the medical-surgical nursing unit on 7-22-13 at 1345 hours, a Medtronic Physio-Control LifePak 12 defibrillator was observed on the Emergency Code Cart. The document Daily Crash Cart Checklist located on top of the Code Cart failed to indicate the daily equipment inspections or checks per the manufacturer ' s (Medtronic) Operators Checklist.</p> <p>5. During an interview on 7-23-13 at 1135 hours, staff A3 confirmed that the policy/procedure and Daily Crash Cart Checklist failed to ensure that the equipment was checked in accordance with manufacturer ' s recommendations.</p> <p>6. During a tour of the emergency department unit on 7-23-13 at 1210 hours, a Zoll R Series defibrillator was observed on the adult Emergency Code Cart. The document Daily Safety Checklist located on top of the Code Cart failed to indicate the daily equipment inspections or checks per the manufacturer ' s (Zoll) Operators Checklist for R Series Products.</p>			

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	7. During an interview on 7-23-13 at 1210 hours, staff A15 confirmed that the Daily Safety Checklist failed to ensure that the equipment was checked in accordance with manufacturer ' s recommendations.			