

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150037	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/29/2016
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NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N STATE ST GREENFIELD, IN 46140
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S 0000 Bldg. 00	This visit was for a standard licensure survey. Facility Number: 005035 Survey Date: 06-27-2016 - 06-30-2016 QA: 8/8/16 jlh	S 0000		
S 0270 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up. Based on document review and interview, the governing board failed to review reports of quality activities for 1 contracted service for calendar year 2015, as part of its comprehensive quality assessment and performance improvement (QAPI) program. Findings include:	S 0270	Quality indicator data for the contracted service of biohazardous haul was not provided during the state survey. The Director of Building Services provided documentation of Contract Reporting Quality Indicator Worksheets for 2015 and Quarters 1 and 2 of 2016 following the survey. The following two indicators are	08/31/2016

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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	<p>1. Review of the governing board minutes for calendar year 2015, indicated they did not include review of reports for the contracted service of biohazardous waste hauler..</p> <p>2. In interview, on 06-30-2016 at 1:15 pm, employee #A6, Manager Environmental Services, confirmed the above and no further documentation was provided prior to exit.</p>		<p>monitored: timeliness of service (pickup of waste twice per week) and receipt of destruction manifests for 100% of waste. Both indicators were met at 100% each quarter of 2015 and through June of 2016. This data will be reported at the Hospital Quality Council on August 24, 2016. The Hospital Quality Council will send the meeting minutes including the contract quality indicators for biohazardous waste haul for review by the governing board. Ongoing compliance monitoring will include the Director of Building Services reviewing compliance monthly and submitting the quality indicator worksheet quarterly into the hospital's contract database. The Director of Building Services will report the status of the contract compliance annually in August at the Hospital Quality Council. If the targets are not met, the Director of Building Services will submit a plan of correction or action to the Hospital Quality Council which will also be reviewed by the board through the meeting minutes.</p> <p>Supporting Documents: 1.Meeting Book-Hospital Quality Council Agenda for August 24, 2016 2. Bio-hazardous Waste Removal Quality indicator worksheet for Quarters 1 and 2, 2016. 3. Bio-hazardous Waste Removal Quality Indicator Worksheet for 2015 .</p>	

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S 0308 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B)</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>(B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.</p> <p>Based on document review, observation and interview the facility failed to ensure a department specific orientation was completed for 1 of 1 Infection control manager (N1).</p> <p>Findings include:</p> <p>1. Review of policy/ procedure # 4272, Orientation process, on page 1 indicated the following: <u>Orientation Period</u>: The first 3 months of employment constitute an Orientation Period for new associates. This is a time for adjustment to a new environment. During this timeframe, the new associate's ability to succeed will be monitored and formally documented. The New Associate Orientation Program, as well as department-specific orientation, will</p>	S 0308	<p>Documentation of orientation for the infection control manager was not in found during the survey. The original documentation of orientation on the Infection Control Manager was lost. The Infection Control Manager's preceptor is still employed by the hospital. The orientation checklist was reviewed by the former and current Infection Control Manager and the document was recreated and placed in the personnel file. A new process has been developed and will be implemented on September 12, 2016 with any new hires from that date forward. The associate will not be signed off on as ready to work independently until the appropriate orientation checklist(s) are signed off by all responsible parties and returned to Human Resources. The HR policy 4272 is under revision to</p>	08/15/2016	

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S 0318 Bldg. 00	<p>provide a sound foundation for the new associate's adjustment. These programs are coordinated by the Training & Development and Human Resources departments. This policy/ procedure was last reviewed/ revised 3-14-14.</p> <p>2. Review of the personnel file for N1, Infection Control Manager, indicated a lack of documentation of a department-specific orientation.</p> <p>3. Interview on 6-29-16 at 1245 hours with staff # 60, Human Resource Director confirmed the lack of a department specific orientation for N1.</p> <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F)</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>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who</p>				<p>reflect this change. Supporting Documentation: 1. Orientation evaluation and Department Orientation Checklist for Infection Control Manager.</p>		

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	<p>provide direct patient care.</p> <p>Based on document review and interview the facility failed to ensure Cardiopulmonary Resuscitation (CPR) certification for 1 of 1 Infection Control Manager (N1), and 1 of 2 Patient Care Techs (N2).</p> <p>Findings Include:</p> <p>1. Review of policy/ procedure # 4117, Educational - Annual Requirements, on page 1 indicated the following: <u>CPR</u>, <u>BLS (Basic Life Support)</u>, <u>ACLS (Advanced Cardiac Life support)</u>, <u>PALS (Pediatric Advanced Life Support)</u>, and <u>NRP (Neonatal Resuscitation Program) requirements</u>- If the associate's job description requires active CPR/ ACLS certification, the associate is responsible for maintaining active certification from the American Heart Association Basic Life Support for Healthcare Providers Program. This policy/ procedure was last reviewed/ revised 2-28-14.</p> <p>2. Review of job description INFECTION CONTROL MANAGER on page 2 indicated the following: C. MANDATORY LICENSE/REGISTRATION/CERTIFICATION: The following license/ certifications are</p>	S 0318	<p>Lack of documentation of CPR for the Infection Control Manager and 1 Patient Care Tech. The Infection Control Manager has no direct care interaction with patients. The job description was amended by the Director of Health Information Services and Quality to reflect that CPR is not needed for this position. The Patient Care Tech completed her CPR training on August 16, 2016. The Patient Care Tech was CPR certified from a previous job but failed to provide a copy of the card. Human Resources and Clinical Education have developed a new process in which any new hire without a card on the day of hire will be scheduled for the next CPR class. This class will be completed within 30 days of hire. The Patient Care Tech will not provide patient care independently until CPR is completed. Supporting documents:</p> <p>1. Job Description for the Infection Control Manager showing the position does not require CPR</p> <p>2. BLS Provider Card for Patient Care Tech</p>	08/16/2016

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S 0406 Bldg. 00	<p>required (if checked): (checked box) CPR (Cardio-Pulmonary Resuscitation).</p> <p>3. Review of job description PATIENT CARE TECH on page 1 indicated the following: C. MANDATORY LICENSE/REGISTRATION/CERTIFICATION: The following licenses/certifications are required (if checked): (checked box) CPR (Cardio-Pulmonary Resuscitation)</p> <p>4. Review of personnel files for N1, Infection Control Manager, and N2, Patient Care Tech, lacked documentation of a current certification for CPR.</p> <p>5. Interview on 6-29-16 at 1245 hours with Staff # 60, Human Resource Director, confirmed the lack of documentation of a current CPR certification for N1 and N2.</p> <p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The</p>			

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	<p>program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to have a monitor and standard for quality activities for 1 contracted service for calendar year 2015, as part of its comprehensive quality assessment and performance improvement (QAPI) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility ' s QAPI minutes and reports for calendar year 2015, indicated they did not include a monitor and standard for the contracted service of biohazardous waste hauler. 2. In interview, on 06-30-2016 at 1:15 pm, employee #A6, Manager Environmental Services, confirmed the above and no further documentation was provided prior to exit. 	S 0406	<p>The facility failed to have a monitor and standard for quality activities for 1 contracted services-Biohazardous Waste Haul. The Director of Building Services provided documentation of Contract Reporting Quality Indicator Worksheets for 2015 and Quarters 1 and 2of 2016 following the survey. The following two indicators are monitored: timeliness of service (pickup of waste twiceper week) and receipt of destruction manifests for 100% of waste. Both indicators were met at 100% each quarterof 2015 and through June of 2016. This data will be reported at the Hospital Quality Councilon August 24, 2016. The Hospital Quality Council will send the meeting minutes including the contract quality indicators for biohazardous waste haul for review by the governing board. Ongoing compliance monitor will include the Director of Building Services reviewing compliance monthly and submitting the quality indicator worksheet quarterly into the hospital's contract database. The Director of Building Services will report the status of the contract compliance annually in August at the Hospital Quality</p>	08/31/2016

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S 0952 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy/procedure review, and transfusion record review the facility failed to follow approved medical staff policies and procedures for 2 of 6 blood transfusions reviewed.</p> <p>Findings included:</p> <p>1. Review of a policy/procedure titled: "Blood and Blood Product Products Administration, Policy #: TX 770, Rev. Date: 3/14/14. Eff. Date: 3/31/14" which stated:</p> <p>a. "2. A pre-transfusion set of vital signs will</p>	S 0952	<p>Council. If the targets are not met, the Director of Building Services will submit a plan of correction or action to the Hospital Quality Council which will also be reviewed by the boardthrough the meeting minutes. Supporting Documents: 1. Hospital Quality Council Agenda 2. Quality Indicator Worksheet for monitors Quarter 1 and 2, 2016 3. Quality Indicator Worksheet for monitors 2015</p> <p>Blood transfusion documentation did not meet the hospital's policy on 2 of 6 record reviews. The policy of Blood and Blood Product Administration was changed to make the process clearer to nursing on obtaining transfusion vital signs. Per the revised policy, vital signs will betaken within 45 minutes prior to starting the transfusion. Transfusion vital signs will be taken at 5-15 minutes from start of transfusion,</p>	08/31/2016

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S 1028 Bldg. 00	<p>be obtained before going to pick up blood product."</p> <p>b. "9. Obtain vital signs during blood product transfusion: 1. 5 to 15 minutes after transfusion started. 3. When transfusion of unit is complete."</p> <p>2. Review of transfusion records revealed</p> <p>a. T (Transfusion) #3 record indicated the pre vital signs were taken at 13:10, the same time the transfusion was started, but the blood was picked up at 12:52. The pre vitals were not done before blood pickup per approved medical staff policy/procedure.</p> <p>b. T#6 record indicated the pre vital signs were taken one hour before the start of the transfusion at 21:46, and the 5 to 15 minutes vitals were taken at 00:24, long past the 5 to 15 minutes noted in the approved medical staff policy/procedure.</p> <p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E)</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>(E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical</p>		<p>periodically throughout the transfusion and at completion of transfusion. The Meditech Transfusion Administration Record has been revised to allow for the vital signs to be entered in this manner. Education to staff on this change will be completed by August 31, 2016. Transfusion administration records will be monitored by Blood Bank. Any variations in vital sign documentation from the policy will be reported through our Event Management System. The appropriate Director for the employee involved will provide re-education on the process to the employee. This is an ongoing monitoring process and all transfusions are reviewed.</p> <p>Supporting Documents: 1. Nursing Policy TX 770 Blood and Blood Product Administration.</p>	

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S 1118 Bldg. 00	<p>staff, when the pharmacist is absent. Based on observation, document review, and interview the facility failed to ensure only authorized staff could access medications in 1 instance.</p> <p>Findings:</p> <p>1. On 06-27-2016 at 3:55 pm, in the presence of employees #A2, Plant Operations Manager, and #A3, Safety Coordinator, it was observed in the Cardiovascular treatment area, employee #A9, an unlicensed Rehab Technician, had access to a locked medication (nitroglycerine).</p> <p>1. Review of POLICY #: TX P 740, REVISED: 5/16, entitled Medication Administration - Who May Administer Medications, did not include Rehab Technician.</p> <p>2. In interview, on 06-28-2016 at 3:45 pm, employee #A3, Safety Coordinator, confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p>	S 1028	<p>Facility failed to ensure only authorized staff access medications in one instance. Upon notification of this citation, the Director of Rehabilitation Services removed the nitroglycerine from the Cardiac Rehabilitation area. The area will be randomly monitored weekly by the Director of Rehabilitation Services.</p>	07/01/2016	

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	<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, the facility created conditions which resulted in a hazard to patients or employees in 2 instances.</p> <p>Findings include:</p> <p>1. On 06-27-2016 at 11:00 am, in the presence of employees #A2, Plant Operations Manager, and #A3, Safety Coordinator, it was observed in offsite OS#1, Parkway Medical Center Imaging Suite, in the MRI (Magnetic Resonance Imaging) equipment room, there was the following:</p> <p>a. a large portion of a wall was open and contained many electrical wires, cables and connectors for the MRI equipment. This posed a safety hazard if anyone accidentally contacted this part of the wall.</p> <p>b. the elevated floor, approximately 1 foot, contained an opening approximately 2 feet square. This posed a safety hazard</p>	S 1118	<p>Facility created conditions which resulted in a hazard to patients or employees in two instances. In the Parkway Imaging Center, the covering for the wires and cables had been removed from the MRI equipment. There was also an approximate two feet square opening in the raised floor. Upon discovery, Clinical equipment was notified and the panels to cover the wires and cables were replaced. Maintenance has covered the hole in the raised floor with a removable plate so that the hole is covered. This also allows for access to the MRI equipment pieces located under the raised floor. All other MRI sites were visited by the facilities staff to ensure their equipment was in compliance.</p> <p>Building services will randomly inspect the sites monthly to ensure the covers are in place. The Safety Officer will visit this area quarterly to ensure compliance. Supporting Documents:</p> <p>1. Photos of the replacement of the wire and cable covers and</p>	08/17/2016

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S 1160 Bldg. 00	<p>if anyone's foot accidentally slipped into the opening.</p> <p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(1)</p> <p>(d) The equipment requirements are as follows:</p> <p>(1) All equipment shall be in good working order and regularly serviced and maintained.</p> <p>Based on document review and interview, the facility failed to have an appropriate policy to regularly service and maintain patient care equipment.</p> <p>Findings include:</p> <p>1. Review of POLICY #: 8006, entitled MEDICAL EQUIPMENT MANAGEMENT PLAN, EFF. DATE: 9/13, indicated the facility would use a "Risk Based Service Approach".</p> <p>2. In interview, on 06-28-2016 at 1:50 pm, employee #A3, Safety Coordinator, indicated the facility did not have a waiver from the State to use such a risk-based service program. No other documentation was provided prior to exit.</p>	S 1160	<p>placement of a plate to cover the opening in the raised floor.</p> <p>The facility failed to have an appropriate policy to regularly service and maintain patient care equipment. Review of Policy 8006 indicated the facility would use a risk based approach but does not have a waiver from the state to use this type of program.</p> <p>On August 11, 2016 the Safety Committee met and discussed the citation. The committee supported the application for the waiver. A waiver requesting the use of a "risk based approach" was mailed and faxed to the state on August 15, 2016. This waiver is to deviate from periodic inspections and manufacturers' recommended maintenance schedules in accordance with the policy 8006.</p> <p>At this time, the hospital is awaiting the waiver. At such time as the waiver is received, a copy</p>	08/15/2016

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S 1166 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(C)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks. Based on document review and interview, the hospital failed to document a current leakage check on 4 of 23 pieces of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 06-27-2016 at 10:30 am, employee #A2, Plant Operations Manager, was requested to provide documentation of current electrical leakage checks for 23 pieces of equipment. Review of documents indicated there was no documentation of current electrical leakage check for a CT 	S 1166	<p>will be kept with policy 8006. Supporting Documents: 1. Safety Policy 8006 2. Safety Committee minutes from August 11, 2016.</p> <p>The facility failed to document a current leakage check on 4 of 23 pieces of equipment.</p> <p>The Clinical Equipment Manager commented on 3 of the 4 pieces of equipment stating, "These three devices, the CT scanner, gamma camera and mammogram scanner are all hardwired into position." Documentation is attached, provided by the ClinicalEquipment Manager from NFPA 99 Health Care Facilities Codes and from the Association for the Advancement of Medical Instrumentation on current leakage. This information was</p>	08/18/2016

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NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N STATE ST GREENFIELD, IN 46140
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	<p>Scanner, dietary dishwasher, gamma camera, and a mammogram scanner.</p> <p>3. In interview, on 06-28-2016 at 2:15 pm, employee #A5, Clinical Equipment Manager, confirmed there was no above-requested documentation. No other documentation was provided prior to exit.</p>		<p>provided to the facility by ARAMARK's Director of Quality and Compliance.</p> <p>The Director of Building Services also commented regarding the dishwasher that it is hardwired and follows the same standards as above.</p> <p>Supporting Documents: 1. Letter from Aramark 2. Healthcare Facilities Code 3. Electrical Safety Manual 2015 Edition Addendum 9/25/16 Additional information on S-1166</p> <p>1.How are you (the licensed facility) going to the correct the deficiency? The policies on clinical equipment and other hospital equipment have been updated to include clearer definition of current leakage on hard wired equipment. All hardwired equipment will be checked at installation for current leakage. A log has been developed by both Clinical Equipment and Building Services to track current leakage upon installation of hardwired equipment. The result of this test will be logged and kept for reference in the appropriate department (Clinical Equipment or Building Service). This log has been implemented as of 9/26/16.</p> <p>2.How are you (the licensed facility) going to prevent the deficiency from reoccurring in the future, even if it is already</p>	

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			<p>corrected? The Director of Building Services has educated the staff of both Building Services and Clinical Equipment on the policy to check all hardwired equipment of the hospital and its associated facilities for current leakage at the time of installation. These departments (Building Services and Clinical Equipment) will work with the vendors or installers to ensure this test (current leakage) is completed. The staff person assigned to installation will ensure that the current leakage meets the policy requirements. They will document the reading on the log for future reference. The Director of Building Services will monitor the log for completion.</p> <p>3. Who is responsible for number 1 and 2 above? The responsible party for ensuring compliance with policy and log completion is the Director of Building Services.</p> <p>4. By what date will you have the deficiency corrected? All policies changes, logs and education of the involved staff will occur by September 30, 2016. The Director of Building Services will review a list of any newly installed equipment against the logs weekly for 4 weeks. Any identified issues will be addressed with staff or vendors involved. An ongoing monthly monitoring of the current leakage log will occur for the next 12 months. Checking of log on</p>	

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S 1186 Bldg. 00	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 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 include in its fire control plan a provision to cooperate with firefighting authorities in 1 instance</p>	S 1186	<p>newly installed hardwired equipment will be added to the Safety Officer's Safety Rounds. Any issues identified during these rounds will be reported to the Director of Building Services and corrected.</p> <p>The hospital Safety Committee corrected our Fire Alert policy #9001 to include a section that directs our hospital to cooperate with firefighting authorities. The committee voted to approve the changes to this policy at our</p>	08/31/2016

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility POLICY #: 9001, entitled FIRE ALERT, EFF. DATE: 02/16, indicated it did not include a provision to cooperate with firefighting authorities. 2. In interview, on 06-28-2016 at 3:15 pm, employee #A3, Safety Coordinator, confirmed the above and no other documentation was provided prior to exit. 		<p>meeting on 8/11/16 and will put the policy out for staff within the next two weeks. The hospital works in conjunction with our local fire authority on many levels, to name a few: preparedness training, reference for code compliance, and yearly fire inspections. Whenever an alarm occurs at the hospital, whether false or actual, the hospital works with the fire department to ensure the situations are evaluated and handled accordingly. To ensure we are compliant with our policy in the future, the newly added statement to our policy will be kept and followed by staff. The policy reads and will remain to read in the future the following: "The hospital will work in conjunction with the local Fire Department during our Fire Alert situations, following direction of the Fire Commander in charge of the situation." We will continue to monitor our Fire Alert policy for any improvements that can be made and to ensure we are complying with all regulatory requirements to the policy as well. Supporting Documents 1. Safety Committee minutes August 11, 2016 2. Revised Safety Policy 9001</p>		