

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/30/2012
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NAME OF PROVIDER OR SUPPLIER  SAINT CHARLES SURGICAL PAVILLION	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SAINT CHARLES ST JASPER, IN 47546
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 002523</p> <p>Survey Dates: 5-29/30-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 06/18/12</p>	S0000		

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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S0156	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and staff interview, the facility failed to ensure annual performance evaluations were performed for 4 of 7 Registered Nurses.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of personnel files for staff members #N1, N2, and #3 indicated that the last performance evaluation was dated 1/11.</li> <li>2. Review of staff member #4 personnel file indicated that his/her last performance evaluation was dated 6/09.</li> <li>3. Staff member #1 verified the above at 4:45 p.m. on 5/29/12.</li> </ol>	S0156	<ol style="list-style-type: none"> <li>1. All registered nurse staff will receive an annual performance evaluation. This evaluation will be completed within 30 days of the prior evaluation.</li> <li>2. The administrator will formulate and administer the staff evaluations.</li> <li>3. All evaluations will be reviewed and accepted by the Medical Director prior to implementation.</li> <li>4. All outstanding evaluations identified have been completed and are within the annual time frame.</li> <li>5. The administrator is will be responsible for evaluation performance annually.</li> <li>6. Staff evaluations due dates will be tracked in an EXCEL worksheet on the administrator desktop and will be checked monthly. This process will prevent late evaluations.</li> </ol>	06/25/2012

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S0332	<p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained.</p>			

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	<p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to</p>			

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	<p>the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is</p>			

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	<p>progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the center.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p>			

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	<p>Based on document review and interview, the facility failed to develop a policy/procedure to determine reportable occurrences, those reportable to the Indiana State Department of Health (ISDH), that occur within the center.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of facility documents on 5-29-12 and 5-30-12 lacked evidence that the facility had developed a policy/procedure to determine reportable occurrences, those reportable to the ISDH, that occur within the center.</li> <li>Interview with B#1 on 5-30-12 at 1410 hours confirmed the facility had not developed a policy/procedure to determine reportable occurrences, those reportable to the ISDH, that occur within the center.</li> </ol>	S0332	<p>1. A policy &amp; procedure was developed identifying the 28 reportable events at the facility. This P&amp;P includes a tracking tool for all 28 events defined. This policy was presented to the Medical staff and the Governing Board and was accepted in the second quarter meetings held 6.25.2012. The tracking tool will be utilized to generate a quarterly report which will identify any event deemed reportable. This information will be included in the quarterly Medical Staff and Governing Board meetings. The data will be entered into the tracking tool weekly and the information will be presented to the medical staff and governing board by the administrator. This information will be reflected in the meeting minutes for the Medical Staff and the Governing Board each quarter.</p>	06/25/2012			

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S0334	<p>410 IAC 15-2.4-2.2(a)(2) QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) center employee involved; or any other information.</p> <p>(2) A potential reportable event may be identified by a center that:</p>			

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	<p>(A) receives a patient as a transfer; or</p> <p>(b) admits a patient subsequent to discharge; from another health care facility subject to a reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.</p> <p>(e) Any serious reportable listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the center between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)</p> <p>Based on document review and interview,</p>	S0334	Following P&P development and	06/25/2012

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	<p>the facility failed to include reportable occurrences, those reportable to the Indiana State Department of Health, in the facility Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of facility documents on 5-29-12 and 5-30-12 lacked evidence the facility included reportable occurrences, those reportable to the ISDH, in the facility QAPI program.</li> <li>2. Interview with B#1 on 5-30-12 at 1350 hours confirmed the facility has not included reportable occurrences, those reportable to the ISDH, in the facility QAPI program.</li> </ol>		<p>acceptance by the Medical Staff and Governing Board, all reportable occurrences (28) will now be included in the quarterly QAPI program. A quarterly report will be generated by the administrator that includes the results of the data accumulated during daily tracking of events designated in the P&amp;P. This data will be included in the quarterly Medical Staff and Governing Board meetings and reflected in the minutes thereof.</p>		

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S0414	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on document review and staff interview, the facility failed to establish an infection control committee.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of facility meeting minutes indicated the facility had no established infection control meeting.</li> <li>Staff member #3 verified in interview</li> </ol>	S0414	<p>1. Infection Control Committee for Saint Charles Surgical Pavilion was appointed. The committee includes: Infection Control Officer who is a registered nurse Administrator Certified Surgical Technician Dr. Randall Norris 2. The facility infection control committee evaluated and accepted a new infection tracking program. This tracking program includes tools which are thorough and makes it easy to distinguish between SSI</p>	06/14/2012			

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	at 2:00 p.m. on 5/30/12 that the facility did not have an infection control committee.		or not SSI at the facility. 3. Quarterly infection control committee meetings will be held to discuss infection control issues (held 6/14/2012). 4. Infection Control Committee information will be included in the quarterly Medical Staff and Governing Board meetings, and will be reflected in the minutes thereof. 5. The administrator will be responsible for the generation of the quarterly reports and the infection control officer will be responsible for the tracking of the infection information.		

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S0616	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on document review and staff interview, the facility failed to prevent unauthorized access to the physician rubber stamp for 1 of 3 surgeon rubber stamps.</p> <p>Findings include:</p> <p>1. Facility policy titled "Rubber Stampers" last reviewed/revised 9/19/08 states under policy: "Any physician with privileges of this facility may use the rubber stampers as needed."</p> <p>2. Patient #N21 medical record had a rubberized stamped signature for M.D. #1 on document titled "Operative Progress Note".</p>	S0616	<p>1.This policy was reviewed and revised on 6.11.2012. The Policy is now titled the "Date &amp; Signature Stamp" P&amp;P. All policies are to be reviewed and revised as needed on a biannual basis at the facility. This will be the responsibility of the administrator. 2. Only physicians will have access to or utilize signature stamps for printed documents in the patient record. 3. This policy update and regulation was reviewed with all RN staff immediately following survey, and during the 6.14.2012 monthly staff meeting. 4. The person responsible for monitoring the plan of correction will be the administrator.</p>	06/11/2012			

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NAME OF PROVIDER OR SUPPLIER  SAINT CHARLES SURGICAL PAVILLION			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SAINT CHARLES ST JASPER, IN 47546		
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	<p>3. Staff member #4 indicated in interview at 1:50 p.m. on 5/30/12 that the pre/post operative staff use the rubber stamp to stamp the Operative Progress Note document.</p> <p>4. Staff member #3 indicated in interview at 2:00 p.m. on 5/30/12 that he/she had used the rubber stamp for M.D. #1 to stamp the document titled "operative Progress Note" for patient #N21.</p>				

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S0630	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on document review and staff interview, the facility failed to ensure staff that did not complete medical record documents prior to the patient's stay for 1 patient observed.</p> <p>Findings include:</p> <p>1. During observation of care provided to patient #N21 beginning at 10:30 a.m. on 5/5/30/12, the following was found in the patients medical record prior to surgery: (A) A document titled "Operative Progress Note" dated 5-30-12 with all areas completed including, but not limited to, whether a specimen was removed, the post operative diagnosis, and the amount of blood loss.</p> <p>2. Staff member #4 indicated in interview at 1:50 p.m. on 5/30/12 that he/she had completed the form on 5/29/12.</p>	S0630	<p>1. No medical record documents will be placed into the patient record prior to the patient's stay. 2. Newly implemented EMR eliminates the noted document from all patient records. 3. All nursing staff was informed of this rule immediately at time of survey. 4. The administrator is responsible to verify compliance. 5. Spot check evaluations will be done by the administrator to verify compliance.</p>	06/04/2012			

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S0790	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)</p> <p>(c) The anesthesia services of the center must meet the needs of the patient, within the scope of the services offered, in accordance with acceptable standards of practice, and must be under the direction of a licensed physician with specialized training or experience in the administration of anesthetics. The anesthesia service is responsible for all anesthesia administered in the center as follows:</p> <p>Based on document review and staff interview, the facility to ensure the anesthesia duties were in accordance with scope of practice related to patient orders for 15 ( #N2-N8 and N13-N20) of 15 records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Patients #N2-N8 and N13-N20 medical record contained orders signed by the CRNA (staff member #1) including, but not limited to, Fentanyl for pain and Zofran for nausea.</li> <li>2. Staff member #1 indicated in interview at 12:00 p.m. on 5/29/12 that he/she does not have prescriptive powers in Indiana.</li> </ol>	S0790	<ol style="list-style-type: none"> <li>1. Surgeons will co-sign all orders generated by Certified Registered Nurse Anesthetists (CRNA) anesthesia providers at the facility.</li> <li>2. Implementation began immediately at time of survey.</li> <li>3. Information was given to all RN and medical staff at facility at time of survey.</li> <li>4. Documentation of co-signature of CRNA anesthesia orders by surgeons will be evaluated on an ongoing basis by Medical Records System chart audits which are done on a quarterly basis.</li> <li>5. The responsible person for implementation &amp; monitoring the plan of correction is the facility administrator.</li> </ol>	05/30/2012

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S0930	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)(5)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following:</p> <p>(5) A provision that all nursing personnel meet annual inservice requirements as established by center and federal and state requirements.</p> <p>Based on document review and staff interview, the facility failed to ensure staff completed annual required training per policy for 3 of 7 Registered Nurses.</p> <p>Findings include:</p> <p>1. Facility policy titled "ANNUAL REQUIRED TRAINING UPDATE" last reviewed/revised 12/1/11 states under policy: "All facility personnel will receive annual update training that include, but are not limited to, general safety, hazardous material and wastes, fire safety, electrical safety, emergency management, infection control, patient safety, HIPPAA and BCLS....."</p> <p>2. Staff members #N1 and #3 and #4 personnel files lacked documentation of annual inservice requirements including, but not limited to, fire safety and infection control.</p>	S0930	<p>1. All nursing staff will be required to receive training in all listed areas annually. A training day is scheduled in October annually. Staff #3 &amp; 4 are personal scrub nurses for the surgeons. They are office employees who do come to the facility with the doctors. They will be required to participate in training day effective immediately.</p> <p>2. If a staff member is unable to attend the annual training day, an alternate training opportunity will be arranged for that staff person.</p> <p>3. The administrator will monitor attendance of staff and is responsible for monitoring the plan of correction.</p>	06/04/2012			

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	3. Staff member #1 verified the above at 4:45 p.m. on 5/29/12.			

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S1146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must 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 may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the facility created two (2) conditions that may result in a hazard to patients, public, or employees.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. While touring the basement of the facility on 5-30-12 at 0915 with B#2, biohazardous waste was observed stored in the same area as items stored for patient care areas, thus creating possible cross contamination.</li> <li>2. While touring the medical gas storage room on 5-30-12 at 0925 hours with B#2, three (3) oxygen tanks and three (3) nitrous oxide tanks were observed unsecured in the medical gas storage room creating a hazard for patients, public, and employees.</li> <li>3. Interview with B#2 on 5-30-12 at 0915</li> </ol>	S1146	<p>1&amp;3: Bio hazardous waste barrels will be contained with a closed cabinet which will be located in the basement level of the facility. This cabinet will be fabricated specifically to contain the red bio hazardous waste containers. It will be constructed by the facility maintenance department and completion of this project is estimated by 7-15-2012. Storage of the bio hazard barrels will be within the closed cabinet and will be ongoing. The cabinet doors will be labeled with bio hazard signage. 2&amp;4: The restraint chains were secured surrounding the K tanks of oxygen and nitrous oxide immediately upon identification of the issue at the time of survey. Ohio Valley Medical Gas representative, Mike Visk, was called and notified of the safety breach during the survey on 5/29/2012 in the</p>	07/15/2012			

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	<p>hours confirmed the biohazardous waste is stored next to items that are taken into the patient care areas, thus creating a condition that could cause cross-contamination.</p> <p>4. Interview with B#2 on 5-30-12 at 0925 hours confirmed that three (3) oxygen tanks and three (3) nitrous oxide tanks were unsecured in the medical gas storage room creating a hazard for patients, public, and employees.</p>		<p>presence of Billie Jo Fritch (surveyor). This contracted company had delivered new tanks on 5/29/2012. Their delivery person was responsible for failure to replace the restraint chains in the tank room following delivery. Documentation was filed as such in the contracted services Q.A. file. A repeat of such a safety breach will result in the termination of this company's service to the facility. Protocol was developed and implemented 5/31/2012, that the tank room will be inspected by the administrator or anesthesia provider at the beginning of each work day to insure restraint chain placement and tank integrity. The person responsible for monitoring the compliance of these is the facility administrator.</p>		

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S1164	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the facility failed to include two (2) pieces of patient care equipment, wheelchairs and the nurse call system, in the facility's preventative maintenance schedule to ensure the safety and well-being of patients.</p> <p>Findings included:</p> <p>1. Review of facility documents on 5-29-12 lacked evidence that the wheelchairs and the nurse call system were included in the facility's preventative</p>	S1164	<p>1. On 5/31/2012 all wheel chairs were evaluated for basic function by the administrator. All were found to be in working order. 2. All wheel chairs have been added to the preventative maintenance schedule for Diversified Instruments and will begin annual inspection by this company during their scheduled November, 2012 facility visit. 3. The Nurse call light system was evaluated by Joe Olsen (Midwest Medical Representative) on 6/12/2012 and found to be without fail. The nurse call light system has been added to that company's</p>	06/12/2012			

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	<p>maintenance schedule to ensure the safety and well-being of patients.</p> <p>2. Interview with B#1 on 5-29-12 at 1615 hours confirmed that wheelchairs and the nurse call system are not included in the facility's preventative maintenance schedule.</p>		<p>bi-annual preventative maintenance schedule to begin August, 2012. 4. Policy was instituted and nursing staff was informed at time of survey that the function of each nurse call light would be checked daily when monitors are initialized at the beginning of each work day. 5. The person responsible for monitoring compliance is the facility administrator. Documentation of the QA will be found in the reports of inspection from Diversified Instruments and Midwest Medical Gas, LLC.</p>		